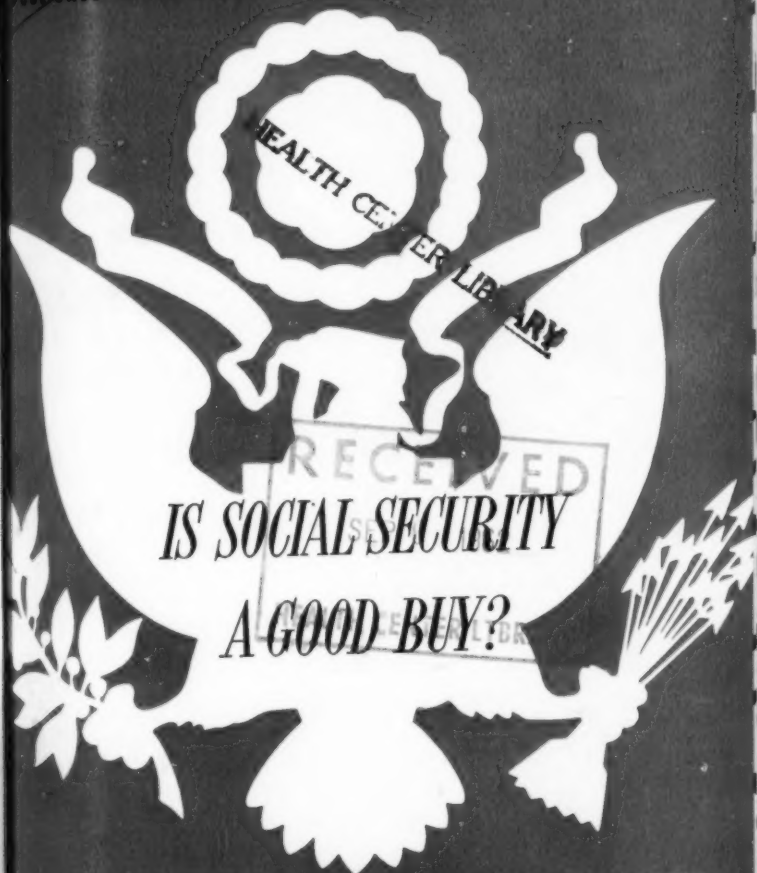


Medical Economics

PUBLISHED EVERY OTHER MONDAY • ISSUE OF FEBRUARY 3, 1989



*IS SOCIAL SECURITY
A GOOD BUY?*

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M.D.s Talk Back to the Plaintiff's Attorney

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1. Proctor, R. C.: *Dis. Nerv. Sys.* 18:223, 1957. 2. Feuss, C. D., and Gragg, L., Jr.: *Dis. Nerv. Sys.* 18:29, 1957. 3. Coats, E. A., and Gray, R. W.: *Dis. Nerv. Sys.* 18:191, 1957. Registered Trademark: Quiactin

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Medical Economics

NEWS BRIEFS

BARGAINS IN BONDS? Three months ago, many were selling at discounts and showing higher yields than stocks. But now bond prices have soared; bond yields have dropped; brokers no longer say "bonds are best buys."

PUBLICIZED FEES: The A.M.A. reports that 483 county medical societies now have standard-fee schedules—and 128 tell the public about them.

IT'S ADULTERY, said the only U.S. court ever to rule on artificial insemination. U.S. physicians have been wary of the procedure ever since. Now a Scottish judge has held it can't be adultery. Medicolegal men predict the courts here will eventually say the same.

A MILLION APPLICANTS have discovered that Federal disability benefits aren't easy to get. Only 324,000 have been found eligible so far; only 120,000 have begun drawing payments.

NEWS BRIEFS

CHIROPODISTS? CHIROPRACTORS? They sound too much alike. So 6,000 of the former group have voted to call themselves podiatrists instead.

10,000 POPULATION is enough to support a general surgeon, internist, OB man, ophthalmologist, pediatrician, or radiologist, leaders in those fields say. Details in next issue.

WHICH HEALTH PLANS return the biggest portion of premium income to subscribers in benefits? Latest official tally: Blue Cross, 92%; commercial group plans, 89%; Blue Shield, 86%; consumer-sponsored plans, 79%; commercial individual plans, 53%.

FUND-RAISING FREEZE: Two biggest charities, the Red Cross and the Polio Foundation, collected less money in 1957 than in 1956. Fund-raisers fear that "givers' resistance" will spread further in 1958.

PRESSURE FROM POLICYHOLDERS has caused the No. 1 malpractice insurer to take the lid off its \$5,000-\$10,000 limits. Details on p. 179.

48-CENT DOLLAR is due before the end of this year. Then it will take a dollar to buy what 48 cents would have bought in 1939.

ADMINISTRATION ATTACK on too-liberal veterans' benefits is being pushed at the highest level. President Eisenhower is acting on the basis of the Bradley Commission's finding that nearly half the population are now ex-servicemen and their families. "If all these people were entitled to veterans' benefits," said Bradley, "one half of the population would be subsidizing the other half."

OVERTIME PAY is a rarity in medical offices, a check-up by this magazine shows. Only one physician in eight compensates his aides in cash for extra hours worked.

"A DEAD ISSUE," Harry Becker now says of Federal health insurance. As one of labor's health experts, he testified in favor of it a dozen years ago. Why does he think it's dead? Because it would impose a new payroll tax on workers for health benefits they're already getting through collective bargaining agreements. Becker calls this type of tax "politically unthinkable" today. Details in next issue.

NEWS BRIEFS

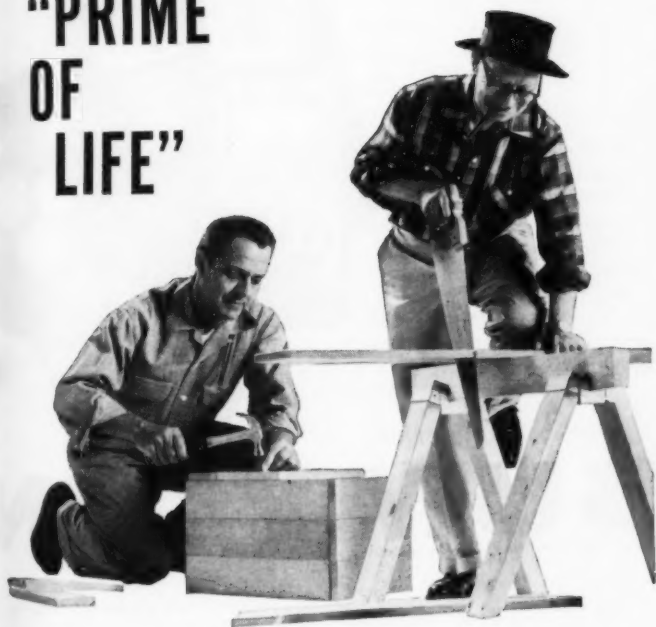
MEDICARE WON'T PAY for office treatment of servicemen's dependents except in accident and maternity cases. M.D.s' "misunderstanding" of this rule is the No. 1 reason for rejected claims, Medicare officials say.

FIRST SCREENING EXAM for foreign medical graduates now in the U.S. will take place Mar. 25. New agency sponsored by the A.M.A. and others will test their command of English, their general medical knowledge, for the guidance of hospitals and state licensing boards.

PRACTICAL POLITICS: "Chances are growing stronger," says the Wall Street Journal, that "Congress will vote a fifth straight election year liberalization of Social Security benefits...One reason: Increased benefits usually go into effect before November elections, while the tax boosts don't start clipping paychecks until the following January."

FEES FOR OFFICE VISITS haven't changed much in five years, a study by this magazine indicates. In 1957 the national medians were \$3 for G.P.s, \$4 for pediatricians and surgeons, \$5 for internists and OB/Gyn. men. That's the same as five years earlier for G.P.s and pediatricians; up a dollar for the rest.

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Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, FEB. 3, 1958

CONTENTS

***Your State Taxes: How They Compare** 69*

Levies on income, sales, and gasoline really dig into your pocket. Here are the amounts a typical doctor pays in each of the 48 states—highest in Vermont, lowest in New Jersey

***How to Make Your Phone Work for You** 73*

Let your aide ask clinical questions, answer nonclinical ones, and make regular collection calls, this man recommends. His advice covers the fine points of office telephone technique

***Too Many Cooks at A.M.A. Headquarters?** 77*

Efficiency experts find some symptoms of bureaucracy, but the A.M.A. trustees decide that they've got the problem licked

***Doctors Talk Back to the Plaintiff's Attorney** 80*

"Is medicine above the law?" Melvin Belli asked in a recent issue. Here's how well-informed physicians answer him—and what they have to say about liability lawyers like Mr. Belli

—MORE ►

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CONTENTS

Is Social Security a Good Buy? 84

Social Security is fundamentally different from private insurance. Nevertheless, some cost-and-coverage comparisons can be made. Here's must reading for all M.D.s

No Surgery for Tomorrow's G.P.!101

This man is training future G.P.s to concentrate on medicine. That probably won't leave much room for the internists

30 Ways to Cut Your Income Taxes113

You can enjoy real tax savings if you deduct all the law allows in these thirty practice-connected categories

Doctors Invent the Damndest Things! 125

Recent patents range from an operable ear to an artificial uterus for premature babies to a belt that reduces hunger

Doctors Seek More Control Over Blue Shield138

This study indicates they'd like their plan to be *really* theirs —and they're eager to cooperate to strengthen the Blues

Malpractice Mishaps: the Money Saved148

This practitioner decided to save his patient's family some hard-earned money. But his thoughtfulness cost *him* plenty

Are You a Medical Robin Hood? 154

You may think you've got good reasons for scaling up your fees according to ability to pay. But here's some food for thought

MORE ➤



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CONTENTS

***Three Ways to Get Faster, Better Histories*171**

You can speed up the interview by looking for turning points
—and by summarizing frequently as you go along

***Low Liability Limits Are Being Raised*179**

The country's number-one exponent of *minimum* malpractice
limits has finally seen the need for moderate-to-high ones

NEWS

How to Build Up Your Estate Quickly 31

First-Aid Chart Helps Patients—and M.D.s 31

Medicare Fees Found to Vary Widely 32

Speed-Up Looms in Medical Education 37

Enforcing Ethics Called Local Doctors' Duty 42

Medical Society Sued for Barring U.M.W. Doctors 44

Rx to Get More Doctors: Two-Year Schools 49

Blue Plan Rate Request Stirs Opposition 54

Druggists Test a Flat \$2 Mark-Up on Rx's 60

How to Run a Hospital Without Much Capital 62

OTHER DEPARTMENTS

News Briefs 1 Publisher's Memo 208

Letters17

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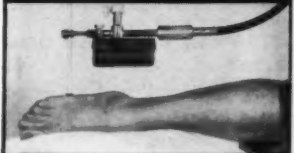


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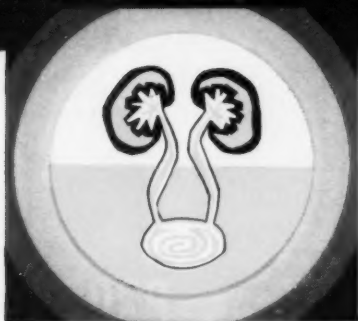


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Letters

Socialization Coming?

SIRS: I've been pondering the following statement in a recent news item: "Of all the patients hospitalized on a typical day last year, a whopping 74 per cent were in government hospitals—Federal, state, or local."

The degeneration of our present medical care system to a socialized status is more advanced than most people realize.

Edward Palmer, M.D.
Berwyn, Ill.

Patients' Records

SIRS: You've published many articles on the subject of medical records. But I don't believe you've pointed out the need for recording patients' histories and their discussion of symptoms *in their own words*. Let me illustrate:

Suppose a poorly educated patient reports that his father died of "Bright's disease." If the doctor notes down "nephritis" instead, he's putting a technical term into

the mouth of a semi-literate person. This alone might cast a doubt on the accuracy of the whole record if it ever became legal evidence.

Then, too, not all doctors interpret laymen's language in the same way. And any subsequent physician who reads a patient's record should be allowed his own interpretation. "I used to take drugs for sleeping" might mean that the patient took opiates—or that he took barbiturates. It seems to me the recording doctor has no right to paraphrase such a statement.

The emotional coloring of the patient's words is also important—and a paraphrase may bleach it out. "Agony," "misery," "sick feeling," are mirrors of mood. They lose their emotional significance when rephrased into medical English.

Henry A. Davidson, M.D.
Cedar Grove, N. J.

SIRS: In a referral, or when a patient decides to change doctors,

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*New and Unused Therapeutics Committee, Am. Coll. Allergists: Interim Report at Thirteenth Annual Congress, Mar. 20-22, 1957, Chicago, Ill., Ann. Allergy, to be published.



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LETTERS

should the original doctor transfer that patient's records to his successor? I don't think he should even though the patient asks him to do so.

I do think the doctor should operate to the extent of supplying his successor with a *copy* or *abstract* of the medical records, not the originals. It has been my experience that when X-rays and other records are lent to another physician, they're seldom returned. Yet such records may constitute an important defense against possible malpractice suits.

Albert E. Marland Sr., M.D.
Washington, D.C.

Why You're a Doctor

SIRS: Dr. Karl Menninger may have had his tongue in his cheek when he discussed the psychological reasons why men go into various fields of medicine. Surely he doesn't *believe* that surgeons, for instance, are seeking "to conceal conscious or unconscious sadism"—or that obstetricians have an "unconscious infantile wish to become [mothers]." He's too good a doctor to take that kind of psychoanalytical chatter seriously.

Obviously, we go into medicine for social, economic, and family reasons. And the decision to specialize usually isn't made at graduation time, after the student has been exposed to the various disciplines of medicine. He chooses his own special field because he takes to it more easily or because

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LETTERS

it seems to offer better material prospects—not because of subconscious falderal.

M. Chamurich, M.D.
Peekskill, N. Y.

Embezzlement Tip

SIRS: "Better Check Your Embezzlement Exposure" was an excellent article. May I add a suggestion for any doctor who may suffer an embezzlement loss?

If he decides not to prosecute and not to demand repayment of the embezzled funds, the money becomes lawful income of the embezzler. So the doctor should report the case to the Internal Revenue Service. The embezzler will then have to pay Federal income tax on any money that hasn't been returned.

William R. Hum
Management Service for Doctors
Vaco, Tex.

Rx Requirements

SIRS: One of your news stories quotes me as having said the Food and Drug Administration "intends to continue authorizing over-the-counter sales of any drug that can be labeled for safe self-medication." I'd like to explain what's behind this policy:

The law recognizes that a citizen has a right to medicate himself. And it states that a supplier of drugs must include in his labeling "adequate" directions for use of the drug, as well as warnings against incorrect or excessive usage. This clearly implies that no

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LETTERS

drug may be restricted to prescription sale *solely* because it requires such labeling.

The Durham-Humphrey Law defines certain types of drugs that must be restricted to prescription sale. But it gives the F.D.A. no administrative authority to *list* such drugs. If we disagree with the manufacturer of a drug about its distribution, the issue can be decided only in the Federal courts.

The same law provides that a drug may be changed from prescription-only to over-the-counter status when no threat to public health is involved. But the F.D.A. has not initiated such switches. When a manufacturer requests a

changeover to nonprescription sale, the proposal must be supported by substantial evidence.

The important *legal* question, so far as safety is concerned, is whether or not a drug is safe *when used according to the directions on the label*. In administering the law, we must assume that those directions will be read and followed. But let there be no mistake: If we believe a product will adversely affect the public health when sold without prescription, the F.D.A. will be the first to object.

George P. Larrick

Commissioner of Food and Drugs
Dept. of Health, Education, and Welfare
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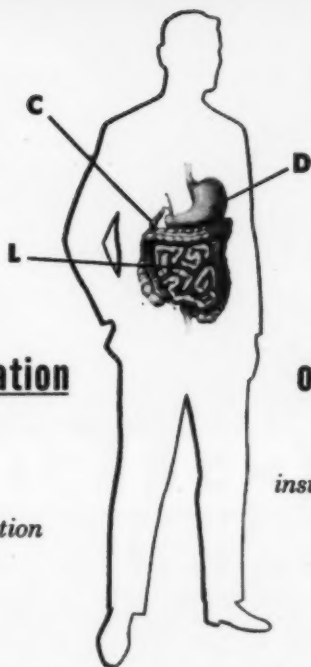
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News

How to Build Up Your Estate Quickly

The cost of living and of practicing medicine probably doesn't leave you enough money to provide for your family's future in the way you'd like. Is there any answer? Yes, a panel of experts recently told doctors in Hartford, Conn.: decreasing term insurance.

It's life insurance whose face value decreases over the years, as your other assets increase and as your children grow up. It has no cash-surrender or loan values, so the premium rates are conspicuously low.* Here's how Hartford doctors heard about it:

For the semi-annual meeting of the Hartford County Medical Society, four financial experts were invited in. These experts (a lawyer, an insurance man, a banker, and an accountant) were asked to consider the various financial problems of "the composite phy-

sician in Hartford County."

This composite physician was described as a 46-year-old specialist, married, with two children. He nets around \$16,000 a year before taxes. He owns a mortgaged home, some life insurance, and a health-and-accident policy. He has invested modestly in securities. He hopes to retire when he's 65.

Question: How can such a man improve his financial position now?

Answer from the experts: He should purchase at least \$100,000 of decreasing term insurance to build up his estate at lowest cost. And a medical society spokesman adds: "Only one of these experts is an insurance man, so I think their conclusion is . . . unbiased."

First-Aid Chart Helps Patients—and M.D.s

"Johnny burned his arm, Doctor. I've washed it with soap and water and covered it with gauze. Can you see him right away if I bring him to your office?" MORE ►

NEWS

That's a well-informed, cooperative mother speaking—and most doctors wish there were more of them. In California, the doctors aren't just wishing. They're sponsoring the distribution of a first-rate first-aid chart designed to fit inside a medicine cabinet door.

In pictures and text, the chart gives simple first-aid directions for twenty-one common injuries: bites, bruises, burns, cuts, fractures, frostbite, etc. And in big red letters the chart warns: **CALL PHYSICIAN IMMEDIATELY. DON'T WAIT!**

The chart has gone over especially well in California's

schools. Several counties have made the instructions "standing orders" in their school systems, the California Medical Association reports.

Medicare Fees Found To Vary Widely

When the Medicare program for military dependents got under way, its critics warned that the Federal Government would in time impose uniform national fees upon participating private physicians. And the size of the developing program hasn't stilled their fears. The Government is now spending "approximately \$5,-

*NEW: FELSOL TABLETS *now available*

SEE YOUR PHYSICIANS' DESK REFERENCE FOR DETAILS

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FELSOL provides *safe and effective relief in asthma, hay fever, and related bronchial affections.*

► **FELSOL** also relieves *pain and fever in arthritis, headaches, rheumatic fever, colds, and flu.*

Ingredients	Each Powder	Each Tablet
Antipyrine	870 mg.	435 mg.
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NOTE: Each powder equals two tablets.

The fast action and long duration of FELSOL gives smooth and comforting relief. After a single therapeutic dose of antipyrine, Brodie and Axelrod report, "Plasma levels declined slowly, measurable amounts of the drug persisting 24 hrs." (J. Pharm. & Exper. Ther. 98:97, 1950)

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*For "sinus drip" . . .
and common infections
of the nose and throat*

Paredrine* Sulfathiazole Suspension

**the most widely prescribed
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◀ **Before** intranasal instillation of 'Paredrine' Sulfathiazole Suspension. Patient suffers severe pharyngitis, complicating ethmoiditis and sphenoiditis. Post-nasal drainage is visible on the posterior pharyngeal wall.

◀ **After** intranasal instillation of Suspension—5 drops in each nostril every two waking hours. (Two hours have elapsed since the last dose.) The microcrystalline sulfathiazole has formed a bacteriostatic film over the infected area, drainage has stopped and inflammation has subsided.

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Laboratories, Philadelphia 1**

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NEWS

000,000 a month" on it, according to Major General Paul I. Robinson, director of Medicare.

But a recent study of allowable Medicare fees indicates that they

vary widely from state to state. The accompanying table lists the highest, lowest, and modal fees that are allowed for fifteen procedures. They're arranged accord-

How Medicare Fees for Fifteen Procedures Vary From State to State

Procedure	Lowest Fee	Highest Fee	Modal Fee	States With Modal Fee
X-ray, diagnostic, complete spine	\$25	\$60	\$45	27
Fracture: radius head, simple, closed	40	75	50	21
Hemorrhoidectomy, internal and external	75	150	100	19
Consultation with complete examination	15	50	35	19
Herniorrhaphy, femoral, unilateral	100	180	150	17
Excision of cervix lesion with dilation and curettage	25	100	50	17
Gastrojejunostomy	150	250	200	16
Tonsillectomy	42½	75	65	15
Carbuncle drainage	4	50	25	13
Thyroidectomy	150	300	225	13
Bronchoscopy; removal of foreign body	70	125	100	12
Classic Caesarean	110	300	200	11
Mastoidectomy	150	390	250	10
Strabismus operation	75	300	200	9
Valvulotomy or commissurotomy	275	600	400	9

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**—unsurpassed antibiotic effects
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Right now the Government is renegotiating its Medicare contracts. But it's aiming merely "to codify existing fees in each area," General Robinson says. "A national schedule could come about only if the physicians themselves should standardize their fees."

Speed-Up Looms in Medical Education

World War II brought on accelerated medical schooling; V-J Day brought an end to it. But now a number of medical colleges are considering the speed-up idea

again. Three of them—Northwestern, Johns Hopkins, and Boston University—are planning to reduce by one or two years the time it takes to become a physician.

So far only Hopkins has released the details of its new program. But the drastic changes it calls for may well indicate what many other medical educators have in mind. Starting next year, twenty-five entering Hopkins students will embark on a schedule that differs in four basic ways from the standard curriculum:

1. *Medical training will begin earlier.* Top students will enter medical school after only two years of college. Students with

in Angina Pectoris

The Attacks Lessen and The Patient Loses His Fear

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LONG-ACTING TABLETS CONTAINING PENTACRYTHRITOL TETRANITRATE (PENT) 10 MG. AND DDAWILIDIP® (ALSERAXYLON) 0.5 MG.

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Compazine's effect is rapid, even at low doses. Side effects are minimal. Especially desirable in nausea and vomiting of pregnancy is the virtual absence of drowsiness and depressing effect with 'Compazine' therapy.

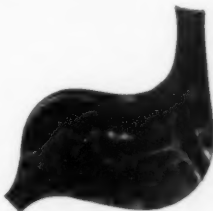
With 'Compazine' Spansule† capsules your patients are afforded all-day or all-night antiemetic protection with a single oral dose.

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Tablets, Syrup and Suppositories. Ampuls and Multiple dose vials for immediate effect.

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NEWS

three or four collegiate years will start in the second-year medical school class. They'll all save at least one year this way.

2. *The medical school curriculum will be broader.* All the standard subjects now thought of as premedical will be taught at medical school. Some humanities will be taught, too—enough to qualify a student for the A.B. degree by the end of his third medical school year, even if he's had only two undergraduate years.

3. *Internships will be an integral part of medical schooling.* The Hopkins plan is for five years in medical school—but with the fifth year a supervised rotating in-

ternship. Students will go into hospitals with 24-hour responsibility for patients.

4. *Medical schooling will be more intense.* The standard thirty-two-week academic year will give way to a forty-week year. The fifth year of training will be fifty weeks long.

What does Johns Hopkins hope to achieve by all this? First, by lopping a year or more from the time it takes to get an M.D. degree, it hopes to reverse the decline in medical school applications. (Nationwide, they've dropped from four for each opening before the war, to less than two for each opening now.)

MORE ►

when anxiety and tension "erupts" in the G. I. tract...

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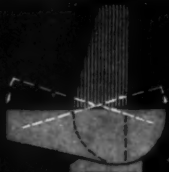


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NEWS

Second, by integrating medical schooling with instruction in the humanities and social sciences, it hopes to produce doctors who understand social factors in disease and who are better equipped to act as leaders in their communities.

Enforcing Ethics Called Local Doctors' Duty

When a doctor disregards medical ethics, his "own colleagues in his own local society must . . . mete out appropriate sanction or punishment if warranted—no matter how . . . distasteful the task may be."

So says the A.M.A.'s Judicial Council, in deploring the tendency of some local ethics committees to pass the buck on to higher authorities. As an example of buck-passing, the Judicial Council cites the following incident:

When charges of patient-soliciting were filed against a prominent doctor in one locale, his county society's ethics committee "did not think it should take any action because of the prominence of the accused in the society and in the community." So the committee asked the society as a whole to consider the charges.

The society voted to turn the case over to the councilor of the

BREAK THE PAIN-SPASM CYCLE OF NEUROMUSCULAR DISORDERS

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fast-acting, well-tolerated, analgesic-antispasmodic that breaks the cycle of pain-spasm-pain associated with rheumatoid arthritis, bursitis, low-back pain, etc. Combines pain relief of potentiated salicylate with skeletal muscle relaxant action of physostigmine salicylate. Muscarinic effects prevented by homatropine methylbromide. Now . . . sodium free.

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When nausea and vomiting
bring a plea for help . . .

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EMETROL

[PHOSPHORATED CARBOHYDRATE SOLUTION]

a safe, pleasant-tasting, oral antiemetic . . .

effective in 6 out of 7 cases of functional vomiting¹—often associated with intestinal "flu" or G.I. grippe. Rapidly effective . . . economical . . . and *safe physiologic action* usually eliminates need for potentially hazardous antiemetic drugs. Also established for safe relief of "morning sickness."²

Dose: children, 1 or 2 tsp.; adults, 1 or 2 tbsp.; repeat every 15 minutes until vomiting ceases. In bottles of 3 and 16 fl.oz. **DO NOT DILUTE.**

1. Bradley, J. E., et al.: J. Pediat. 38:41, 1951. 2. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:311, 1953.



KINNEY & COMPANY, INC. COLUMBUS, INDIANA

when blood pressure

should drift down

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NITRANITOL with
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Dosage: In blood pressures over 200 systolic, 2 tablets four times daily. In other cases, 1 or 2 tablets every four to six hours. Supplied: Bottles of 100 and 1,000.


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NEWS

district. He promptly sent it on to the president of the state society—who "just as promptly requested that the Judicial Council decide" on the matter.

The Judicial Council refused to take the case—partly on the ground that it couldn't prejudge a matter that might later come before it on appeal. Whereupon the president of the state society became indignant. "If there is one thing that is prevalent in this country," he wrote the Council, "it is procrastination. Things which should be settled are referred to committees . . . and time marches on!"

Comments the Judicial Council caustically: "With this statement the Council could not agree more!" Its conclusion: "If local societies fail to curtail unethical practices, ethics lose their effectiveness. Failure on the part of the component society to demand respect for and adherence to the Principles [of Medical Ethics] breeds contempt and disrespect for them."

Medical Society Sued for Barring U.M.W. Doctors

A suit that two Colorado doctors have filed against their county's medical society is being watched with keen interest by medical leaders everywhere. The complaint: that the society is denying the doctors membership solely because of their cooperation with

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NEWS

the United Mine Workers' Welfare and Retirement Fund. The case will probably come to trial within the next few weeks. Its outcome may well determine whether organized medicine can legally punish physicians for participating in health plans that don't permit free choice of physician.

Here are the facts behind the suit:


Surgeon Stanley H. Biber and Internist Robert D. Carlson were licensed in Colorado and began practice in the city of Trinidad in 1954—chiefly treating U.M.W. Fund members, under contract. The Las Animas County Medical Society has since refused to admit

either doctor to membership. It maintains that by being under contract to the Fund, Drs. Biber and Carlson are violating the section of the Colorado Medical Practice Act that prohibits "practicing medicine as an employee of . . . any partnership, association or corporation."

The two physicians maintain that they are "independent contractors . . . who are under no legal obligation to the Fund in the practice of medicine and who in no wise act as employees . . . and who maintain their professional independence at all times."

Drs. Biber and Carlson have asked for a court ruling on wheth-


sustained broad-spectrum antibacterial action

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REFERENCES

- (1) Chan, Y. T. and Hays, E. E., The American Journal of the Medical Sciences, August 1957. (2) Townsend, E. H., Jr. In Press. (3) Weismiller, F., In Press. (4) Cass, Leo I. and Frederik, W. S., In Press.



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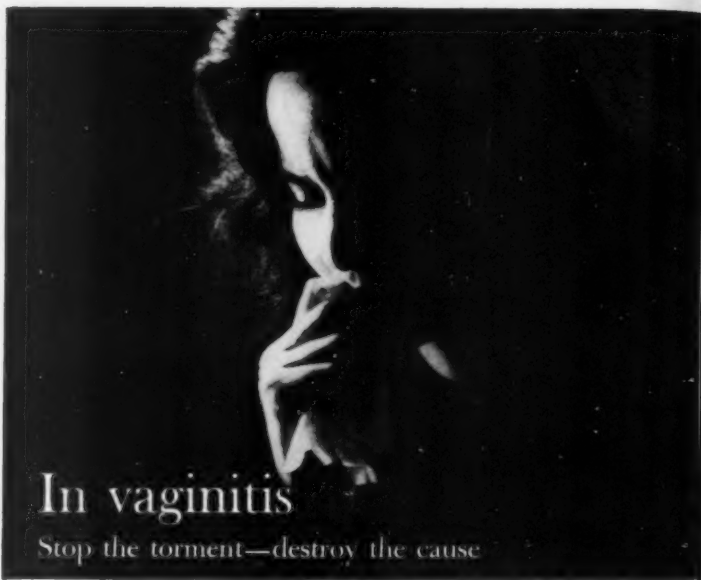
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In vaginitis

Stop the torment—destroy the cause

AVC

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in trichomonal vaginitis —
“... the most effective
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treatment of endocervicitis. ...”³

The rate of cure with AVC Improved is consistently high in all common types of vaginitis. In one series of patients with trichomonal vaginitis bacteriologic cures were obtained in 82.5% of the cases.¹ Symptomatic relief is rapid and lasting. And because AVC Improved has an acid pH, it encourages the early return of normal vaginal flora.

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Administration: An applicatorful twice daily — on arising and at bedtime.

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(1) Cortese, J. T.: Clin. Med. 2:45, 1953.
(2) Hensel, H. A.: Postgrad. Med. 8:291, 1950. (3) Horoschak, A. and Horoschak, S.: J. M. Soc. New Jersey 43:92, 1946.

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NEWS

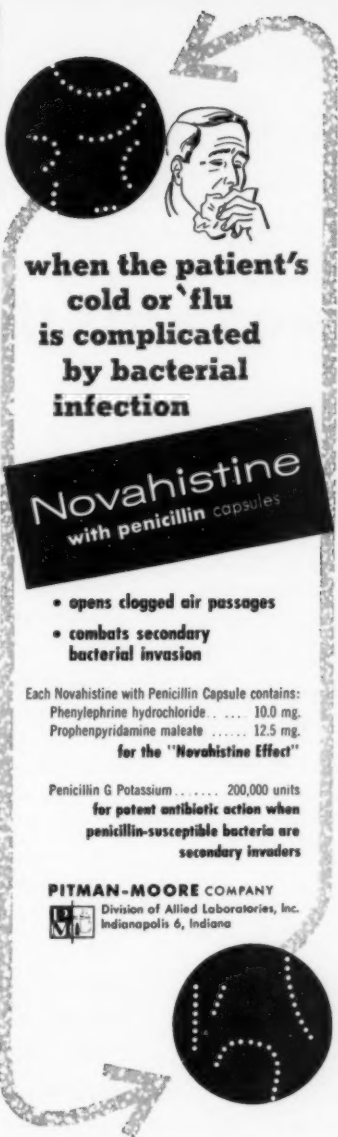
er their relationship to the Fund violates the Medical Practice Act. Each is also asking \$75,000 "compensatory and punitive damages" from the society and seven of its eight members. (The eighth society member also participates in the U.M.W. plan.)

The defendants are charged with having entered into an "agreement and conspiracy to . . . restrain trade in the practice of medicine solely on account of the plaintiff's relationship to the Fund." It's further charged that the defendants, by refusing the two doctors membership in the local society, prevented them from acquiring board certification and kept them off the staff of Trinidad's only hospital.

Why are medical leaders in other states watching the suit so closely? Because, in the words of one of them: "The court's decision will probably help determine the future moves of other medical societies that are contemplating the same action against closed-panel physicians."

Rx to Get More Doctors: Two-Year Schools

How can we ward off a doctor shortage? The answer, according to Dr. John P. Bowler of Dartmouth Medical School, is to open a great many more two-year medical colleges. These would feed graduates into the four-year schools for their last two years of



**when the patient's
cold or 'flu
is complicated
by bacterial
infection**

Novahistine
with penicillin capsules

- opens clogged air passages
- combats secondary bacterial invasion

Each Novahistine with Penicillin Capsule contains:
Phenylephrine hydrochloride 10.0 mg.
Propenpyridamine maleate 12.5 mg.
for the "Novahistine Effect"

Penicillin G Potassium 200,000 units
for potent antibiotic action when
penicillin-susceptible bacteria are
secondary invaders

PITMAN-MOORE COMPANY
Division of Allied Laboratories, Inc.
Indianapolis 6, Indiana

announcing...

Novahistine **LP**^{*} tablets



patients with
colds... sinusitis
... rhinitis will
appreciate the
"Novahistine
LP Effect"

When a patient begins breathing freely in a few minutes... with all air passages cleared... and this relief continues for as long as 12 hours after a single dose... he is experiencing the "Novahistine LP Effect."

This "Effect" is produced by phenylephrine hydrochloride, a quick-acting, orally effective sympathomimetic, combined with chlorprophenpyridamine maleate, a potent histamine antagonist for synergistic decongestive action... on all mucous membranes of the respiratory tract.

Each Novahistine LP Tablet contains:

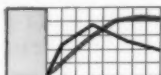
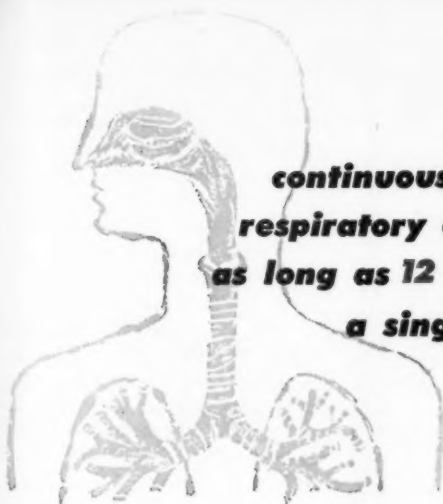
Phenylephrine hydrochloride..... 20 mg.

Chlorprophenpyridamine maleate..... 4 mg.

Supplied in bottles of 50 tablets.

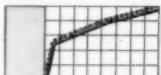
^{*}Trademark

**continuous relief of
respiratory congestion for
as long as 12 hours with
a single dose**



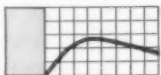
PROMPT RELIEF

Novahistine LP Tablets start releasing medication almost as rapidly as a solution.



CONTINUOUS RELEASE

Novahistine LP releases its decongestive drugs at a constant rate in both acid and alkaline media . . . assuring patients continuous relief whether the tablet is in the stomach or intestine.



SAFE RELIEF

With Novahistine LP there is no sudden "over-release" . . . no uneven, sporadic effects.

And easy to use, oral dosage eliminates patient misuse of nose drops, sprays and inhalants . . . is not likely to produce rebound congestion, mucosal damage and ciliary paralysis, nor make the patient "jittery."

Administration: Adults—2 tablets twice daily will provide an adequate therapeutic effect in the average patient. In resistant cases, a third daily dose may be indicated and can be safely given. Children over six—one-half the adult dose.



PITMAN-MOORE COMPANY

DIVISION OF ALLIED LABORATORIES, INC., INDIANAPOLIS 6, INDIANA

*and...in colds
complicated by
useless, exhausting
coughs*



Novahistine-DH*

(fortified Novahistine with dihydrocodeinone)

When "head colds" become "chest colds" Novahistine-DH promptly controls coughs and keeps air passages of both head and chest clear of obstruction.

Each teaspoonful (5 cc.) of grape-flavored Novahistine-DH contains:

Phenylephrine hydrochloride.....	10 mg.
Propenpyridamine maleate.....	12.5 mg.
Dihydrocodeinone bitartrate.....	1.66 mg.
Chloroform (approx.).....	13.5 mg.
l-Menthol.....	1.0 mg.

Supplied in pint and gallon bottles.

*Trademark



PITMAN-MOORE COMPANY
DIVISION OF ALLIED LABORATORIES, INC.
INDIANAPOLIS 6, INDIANA



NEWS

training. Here's why he thinks the plan would help:

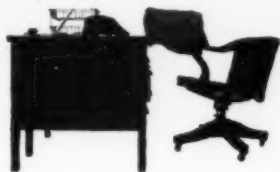
Studies show, he says, "that by 1970 the projected population with its sizable increase in the older population group, plus the steadily increasing demand for research personnel, will require an increased doctor production of at least 2,500 annually above the present rate." If new four-year schools were relied on for this increment, that would mean "100 graduates per year from each of twenty-five new medical schools."

Such schools aren't very likely to appear, Dr. Bowler observes: "There are only a few remaining areas where the development of new four-year schools is possible." Furthermore, "each one of these schools would represent a capitalization of forty to fifty million dollars. It is doubtful whether the national economy will provide for such a large program in a single area of education.

"On the other hand . . . a two-year school associated with a college of liberal arts and turning out approximately fifty men could be established with a capitalization estimated at . . . eight to ten million dollars. These figures [point] to the most economic way to produce more doctors . . .

"There are a number of colleges of liberal arts in which such a program could be incorporated," he points out. "At the other end of the process . . . there are many four-year schools in large metro-

when you treat common bacterial infections...



a well patient back on the job



measures therapeutic success

Pentids

Squibb 200,000 Unit Buffered Penicillin G Potassium Tablets

when an oral penicillin is indicated... prescribe Pentids

Six years experience by physicians in treating many millions of patients with Pentids confirm clinical effectiveness and safety. Excellent results are obtained with Pentids in many common bacterial infections with only 1 or 2 tablets t.i.d. Pentids may be taken without regard to meals. Pentids are economical... cost less than other penicillin salts.

DOSE: 1 or 2 tablets t.i.d. without regard to meals

SUPPLY: Bottles of 12, 100 and 500 tablets

other Pentids products

NEW Pentids For Syrup: Squibb Flavored Penicillin Powder: when prepared with 35 cc. of water, the preparation provides 60 cc. of fruit-flavored syrup, 200,000 units per teaspoonful (5 cc.).

Pentids Capsules: Squibb Penicillin G Potassium 200,000 Unit Capsules, bottles of 24, 100 and 500.

Pentids Soluble Tablets: Squibb Penicillin G Potassium Soluble Tablets - 200,000 units, vials of 12, bottles of 100.

Pentid-Sulfas Tablets: Squibb Penicillin with Triple Sulfas, bottles of 30, 100 and 500.

These formulations are given $\frac{1}{2}$ hr. before meals or 2 hrs. after meals.

SQUIBB



Squibb Quality—the Priceless Ingredient

*PENTIDS® IS A SQUIBB TRADEMARK

NEWS

politan areas that could now increase the enrollment in their third and fourth years at relatively small cost by [using] clinical facilities not presently in use."

The two-year school has "existed as a neglected child for several decades," Dr. Bowler concludes. "It can fill a large and important role in the immediate future . . . The need is for demonstration."

Blue Plan Rate Request Stirs Opposition

Across the country, Blue Cross and Blue Shield plans have been trying to raise their premium rates—and bumping into intense opposition in

the process. Where does it come from? What stands in the way of higher payments to hospitals and doctors? Some typical answers emerge from recent hearings in New York City.

The Blue Cross plan there had requested a rate hike of almost 40 per cent. At hearings called by the State Superintendent of Insurance, the pressures for and against such an increase were dramatically demonstrated.

The pressures for: Charles Gar-side, president of the Blue Cross plan, read off the cold statistics. The plan had lost \$2,500,000 in 1956 and was running more than \$9,500,000 in the red for the first

Only the **LENIC**^{T.M.} complex
provides all five essential polyunsaturated fatty acids

- low dose
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Lenic capsules to lower cholesterol levels and for prophylaxis.

Lenic capsules with niacin to lower cholesterol levels rapidly when coronary disease is identifiable.

Lenic vitamin-mineral capsules for complete daily nutritional support in adult patients.

CROOKES-BARNES LABORATORIES, Inc., Wayne, N. J.

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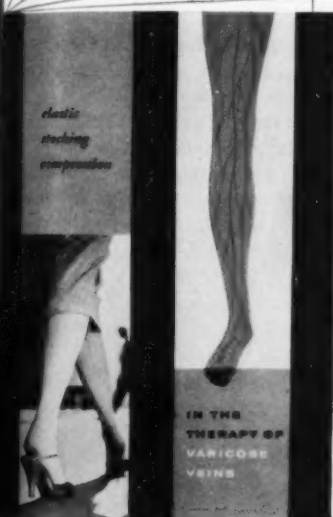
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NEW DIGEST ON THE THERAPY OF VARICOSE VEINS

Handy "refresher course" for your files.

Everything you need to know about the treatment and prevention of varicose veins by compression. Plus a practical guide for prescribing elastic stockings.

Written by a doctor, for doctors. Comprehensive, well-illustrated 34 pages of valuable reference material. Send for your free copy.

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Bauer & Black, Dept. ME-2
309 W. Jackson Blvd., Chicago 6, Ill.

Send me a copy of your new digest on varicose veins and elastic stockings.

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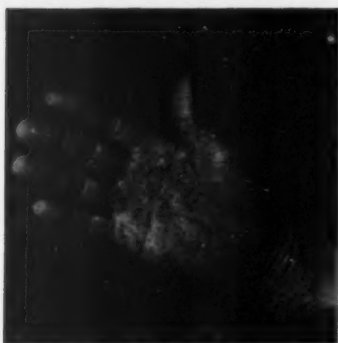
City _____ Zone _____ State _____

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From the leader in elastic stockings

BAUER & BLACK

Division of The Kendall Company



Eczema of 8 years duration



Skin Cleared in only 10 months

MAZON

dual therapy

With MAZON soap, the treatment of choice for Psoriasis, Alopecia and other skin conditions not caused by or associated with metabolic disturbances.

Dispensed only in the original blue jar.

Belmont Laboratories,
Philadelphia, Pa.

nine months of 1957. The main reason? Blue Cross premium rates had remained fixed since 1952, while Blue Cross payments to hospitals had been forced up about 40 per cent.

Support for Mr. Garside came from several of the state's county medical societies, four major hospitals, and two religious charitable groups.

The pressures against: Spokesmen for city government and organized labor raised heated objections to Garside's cold statistics. "The proposed increase . . . would cost city employe subscribers approximately \$1,000,000," said Jerome Clifford of the City Comptroller's office. He added that his study of the Blue Cross financial statement showed "no increase in subscriber rates is warranted at the present time."

Why not? Because the plan had "huge reserves" that could well be used for operating expenses. Among them Mr. Clifford cited a "reserve for epidemics" of \$9,099,000, the need for which is "highly improbable"; and \$20,000,000 of unassigned surplus that "should be available" for operating expenses.

Still stronger opposition came from a local labor spokesman, Walter L. Eisenburg. "There are disturbing signs that commercial thinking and standards have begun to creep into Blue Cross policy-making," Mr. Eisenburg warned. "Blue Cross would be well remind-



time for

Tyzine
brand of tetrahydrozoline hydrochloride

for nasal decongestion

clears nasal passages in *minutes*—without sting, burn or rebound congestion... keeps nasal passages open for *hours*—up to 6 hours without a second dose... abbreviates symptom time... free from unpleasant taste or smell

In more than 1000 patients, "prompt and prolonged mucosal decongestion in nearly all cases."

Nasal Solution, 0.1% • Nasal Spray, 0.1% • Pediatric Nasal Drops, 0.05%

Note: As with certain other widely used nasal decongestants, overdosage may cause drowsiness or sleep in infants and young children. **KEEP OUT OF HANDS OF CHILDREN OF ALL AGES.** Tyzine Nasal Spray and Tyzine Nasal Solution, 0.1%, are not recommended for use in children under six. When using Tyzine Nasal Spray in the plastic bottle, it should be administered only in an upright position.

Roberts, J. G.: M. Times 84:1232, 1956.

Pfizer


PFIZER LABORATORIES Brooklyn 6, New York
Division, Chas. Pfizer & Co., Inc.



"care
of the man
rather than
merely his
stomach"

two-

"Milpath"

Miltown®  anticholinergic

two-level control of gastrointestinal dysfunction

at the central level The tranquilizer Miltown® reduces anxiety and tension.^{1, 3, 6, 7}

Unlike the barbiturates, it does not impair mental or physical efficiency.^{5, 7}

at the peripheral level The anticholinergic tridihexethyl iodide reduces hypermotility and hypersecretion.

Unlike the belladonna alkaloids, it rarely produces dry mouth or blurred vision.^{2, 4}

indications: peptic ulcer, spastic and irritable colon, esophageal spasm, G. I. symptoms of anxiety states.

each "Milpath" tablet contains:

Miltown® (meprobamate WALLACE)	400 mg.
(2-methyl-2-n-propyl-1,3-propanediol dicarbamate)	
Tridihexethyl iodide	25 mg.
(3-diethylamino-1-cyclohexyl-1-phenyl-1-propanol-ethyl iodide)	

dosage: 1 tablet i.i.d. at mealtime and 2 tablets at bedtime.

available: bottles of 50 scored tablets.

references: 1. Altschul, A. and Billow, B.: The clinical use of meprobamate (Miltown®). New York J. Med. 57:2361, July 15, 1957. 2. Atwater, J. S.: The use of anticholinergic agents in peptic ulcer therapy. J. M. A. Georgia 46:421, Oct. 1956. 3. Borrus, J. C.: Study of effect of Miltown (2-methyl-2-n-propyl-1,3-propanediol dicarbamate) on psychiatric states. J. A. M. A. 157: 1596, April 30, 1955. 4. Cayer, D.: Prolonged anticholinergic therapy of duodenal ulcer. Am. J. Digest. Dis. 1:301, July 1956. 5. Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, H. W. and Rapoport, A.: Experimental studies of behavioral effects of meprobamate on normal subjects. Ann. New York Acad. Sc. 67:701, May 9, 1957. 6. Phillips, R. E.: Use of meprobamate (Miltown®) for the treatment of emotional disorders. Am. Pract. & Digest Treat. 7:1573, Oct. 1956. 7. Selling, L. S.: A clinical study of Miltown®, a new tranquilizing agent. J. Clin. & Exper. Psychopath. 17:7, March 1956. 8. Wolf, S. and Wolff, H. G.: Human Gastric Function, Oxford University Press, New York, 1947.



WALLACE LABORATORIES
New Brunswick, N. J.

for **DRY SKIN**

SENILE PRURITUS
INFANT RASHES
WINTER ITCH
BATH ITCH
PSORIASIS
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AVEENO **"Oilated"** *Colloidal* **Emollient Baths**

**AVEENO "Oilated" Baths
provide:**

the recognized relief of a
soothing Aveeno Colloid Bath

plus the skin-softening quality
of emollient oils

Active Ingredients: Aveeno Colloidal
Oatmeal impregnated with a high per-
centage (35%) of liquid petrolatum and
olive oil (U.S.P.).

AVEENO® "OILATED"
is available in 10 oz. cans.

AVEENO CORPORATION

250 WEST 57TH STREET NEW YORK 19, N. Y.

NEWS

ed that it is a nonprofit organiza-
tion [and that it should avoid] the
more lush policies employed by
commercial insurance or other
profit-making enterprises."

The labor spokesman also has
hard at the make-up of the Blue
Cross board of directors. It is
"overwhelmingly peopled by men
[who do not] sit on the board as
representatives of the users of Blue
Cross services," Eisenberg
charged. "We strongly urge . . .
both the enlargement of the Blue
Cross board of directors and the
[selection of] 50 per cent of the
total . . . from organized labor."

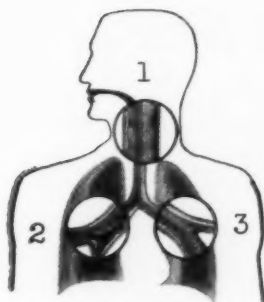
Last month the State Superin-
tendent of Insurance was prepar-
ing his ruling on the requested rate
hike. In view of the pressures for
and against, the proposed increase
seemed almost certain to be com-
promised down to less than the
doctors and hospitals concerned
would like.

Druggists Test a Flat \$2 Mark-Up on Rx's

Some Canadian pharmacists have
been trying out a new system of
prescription pricing. Their aim: to
cut down patients' complaints
about cost. Their new system low-
ers the prices of expensive Rx's and
raises charges for less costly ones.
Here's a brief explanation of the
new system:

Instead of adding a percentage
mark-up to the cost of the ingredi-
ents, these druggists add on a flat

breaks up cough*



* Drawing shows

how 3-pronged attack of Pyrribenzamine Expectorant with Ephedrine breaks up cough by: (1) reducing histamine-induced congestion and irritation throughout the respiratory tract; (2) liquefying thick and tenacious mucus; (3) relaxing bronchioles. Pyrribenzamine Expectorant with Codeine and Ephedrine also available (exempt narcotic). Pyrribenzamine® citrate (tripelennamine citrate CIBA). C I B A Summit, N. J.

NEWS

\$2 "professional fee." An Rx whose ingredients cost \$8 wholesale, for instance, would cost the patient \$10. (The same Rx would cost the patient \$11.20 if the druggist applied the usual 40 per cent mark-up.)

This system lowers the retail price of all Rx's whose ingredients cost at least \$4.50 wholesale, according to Professor H. J. Fuller, head of the Canadian Pharmaceutical Association's pharmaceutical economics committee. On the other hand, it raises the charge for prescriptions wholesaling at \$4 or less.

Professor Fuller, whose committee is compiling the results of

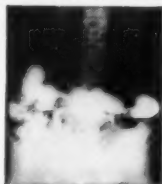
the test, sees financial gains for druggists in the new system. The reason: About 90 per cent of all Rx's sold are made up of ingredients costing \$4 or less. He predicts this pricing system would increase the druggist's income by about \$9,000 yearly, on the average. And all this with fewer complaints from patients.

How to Run a Hospital Without Much Capital

How can small-town doctors get medical-center facilities even if their communities are short on capital? Some interesting ideas for pay-as-you-go financing emerge

when anxiety and tension "erupts" in the G. I. tract...

IN ILEITIS



PATHIBAMATE*

Meprobamate with PATHILON® Lederle

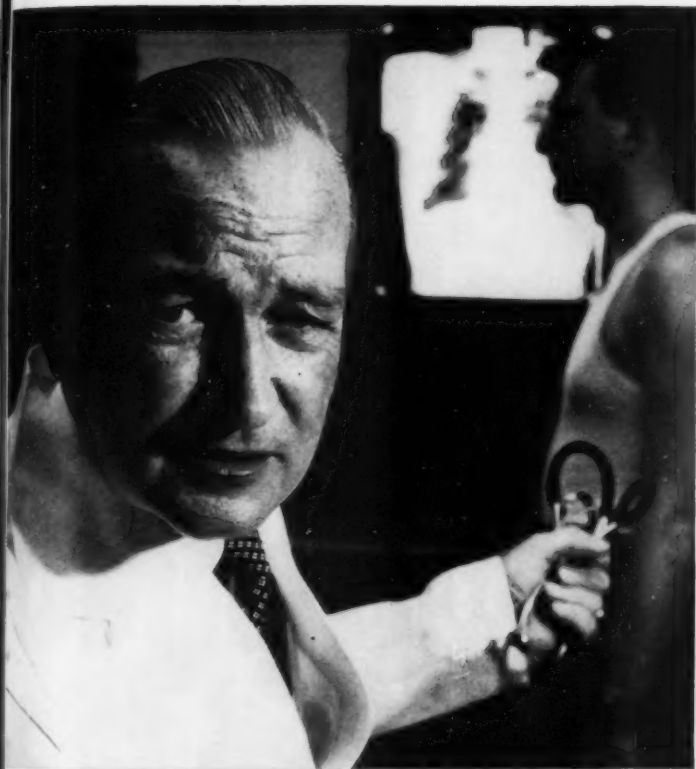
Combines Meprobamate (400 mg.) the most widely prescribed tranquilizer . . . helps control the "emotional overlay" of ileitis — without fear of barbiturate loginess, hangover or habituation . . . with PATHILON (25 mg.) the anticholinergic noted for its extremely low toxicity and high effectiveness in the treatment of many G.I. disorders.

Dosage: 1 tablet t.i.d. at mealtime. 2 tablets at bedtime.

Supplied: Bottles of 100, 1,000.



LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK



"Since we put him on NEOHYDRIN he's been able to stay on the job without interruption."

oral
organomercurial
diuretic

TABLET

NEOHYDRIN®

BRAND OF CHLORMERODIN

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HEALTH CENTER LIBRARY
MEDICAL ECONOMICS FEBRUARY 3, 1958 63

**ALL QUIET
ON THE
COUGHING
FRONT**

“COTHERA”

Brand of Dismantling Hydrant

SYM

NEW COUGH MODERATOR

SPECIFIC ANTITUSSIVE...

"COTHERA" moderates intensity and frequency of coughing through a selective action apparently on the medullary cough center... subdues but does not abolish the cough reflex. The natural reflex for removal of secretions is retained.

ACTS WITHIN MINUTES—LASTS FOR HOURS...

"COTHERA" provides a local anesthetic and soothing demulcent action to induce almost immediate relief of 'sandpaper' throat and 'annoying tickle'... followed by sustained moderation of the cough reflex, lasting for four to six hours and frequently throughout an entire night with one dose.

NON-NARCOTIC...

"COTHERA" is nonaddictive; does not cause respiratory depression, gastric irritation, or constipation. It is well tolerated by children and elderly patients, even after continued use. (Antitussive action is equal to $\frac{1}{4}$ gr. codeine per teaspoon dose.)

GUARDS AGAINST BRONCHOSPASM...

"COTHERA" exerts a mild musculotropic spasmolytic action tending to protect against possible harmful effects and cough-aggravation of bronchospasm.

CHERRY-FLAVORED...

"COTHERA" is completely acceptable to all age groups.

Indications: "COTHERA" Syrup is specifically indicated for irritating, useless, or chronic coughs such as those associated with the common cold, children's diseases, excessive smoking. It may be used safely for short-term or prolonged treatment.

Dosage: Adults and children over 8 years—1 to 2 teaspoonfuls (25-50 mg.) three or four times daily. Children, 2 to 8 years— $\frac{1}{2}$ to 1 teaspoonful three or four times daily.

Supplied: 25 mg. per 5 cc. (teaspoonful), bottles of 16 fluidounces and 1 gallon.

Ayerst Laboratories



New York 16, N. Y. • Montreal, Canada

NEWS

from Louisa County, Va. Local citizens turned the trick this way:

They got a good bit of their initial capital from Hill-Burton funds. They minimized the drain on local capital by building a twenty-three-bed hospital without surgical facilities. (Patients who need major surgery are taken to near-by Charlottesville.) And they provided their new hospital with a built-in rental income. Here's how they did it:

The planners included six rooms to house the county and state health departments. The rental charged these agencies helps pay off the building debt. So does the rental income from five offices in

the basement. These are rented out to local physicians and dentists.

Another pay-as-you-go feature: Hospital charges fluctuate to keep the books balanced. When the hospital shows a surplus, rates are lowered. When it runs into red ink, rates are raised. Thus the hospital can get along without large reserves.

In the five years since the center was built, some 3,300 patients have received hospital care they'd have had to go elsewhere to get before. And now Louisa County is talking about adding a new wing with surgical facilities—to be financed, of course, on the same pay-as-we-go basis.

END



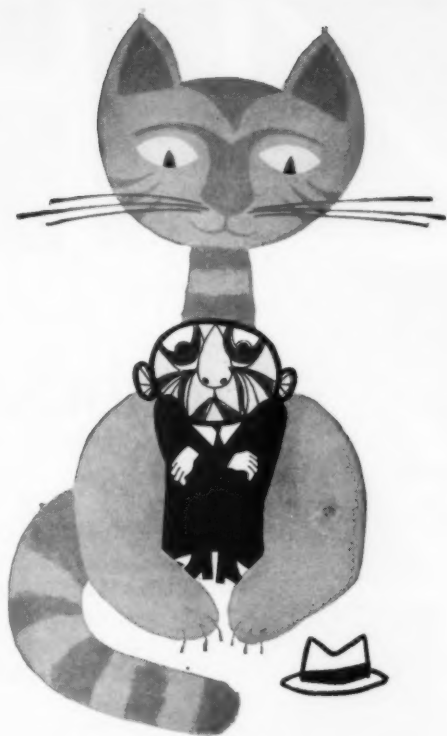
PHENAPHEN[®] PLUS

Phenaphen Plus is the physician-requested combination of Phenaphen, plus an antihistaminic and a nasal decongestant.



Available on prescription only.

each coated tablet contains: **Phenaphen**
 Phenacetin (3 gr.) 194.0 mg.
 Acetylsalicylic Acid (2½ gr.) 162.0 mg.
 Phenobarbital (¼ gr.) 16.2 mg.
 Hyoscyamine Sulfate 0.031 mg.
plus
 Prophepyridamine Maleate 12.5 mg.
 Phenylephrine Hydrochloride 10.0 mg.



"Doctor, I feel like something the cat dragged in."

When the patient complains of such symptoms as loss of appetite, weight loss, fatigue and/or underweight . . .

When you suspect a concomitant nutritional iron deficiency . . .

Counteract this "run-down syndrome" with

TROPH-IRON* TABLETS B₁₂—Iron—B₁

Also available: "Troph-Iron" Liquid for the underpar child, or for adults who prefer a liquid medication.

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off.

a preferred route to follow in topical anesthesia

Tronothane®

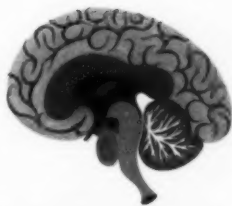
(Pramoxine, Abbott)

Puts safety first while relieving your patient's pain and itching. More than 15,600 case studies showed negligible sensitization and no toxicity was observed.

Abbott

relaxes
both
mind
&
muscle

without
impairing
mental
or physical
efficiency



well tolerated, relatively nontoxic / no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness / well suited for prolonged therapy

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets. *Usual dosage:* One or two 400 mg. tablets t.i.d.

For anxiety, tension and muscle spasm in everyday practice.

Miltown[®]
tranquilizer with muscle-relaxant action

2-methyl-2-propyl-1,3-propanediol dicarbamate

 WALLACE LABORATORIES, NEW BRUNSWICK, N. J.

AN IMPORTANT ADVANCE IN MENOPAUSAL THERAPY

Because it replaces *half* control with *full* control.
Because it treats the *whole* menopausal syndrome.
Because one prescription manages *both* the
psychic and somatic symptoms.

SUPPLIED: Bottles of 60 tablets.

Each tablet contains:

MILTOWN® (meprobamate, Wallace)..... 400 mg
2-methyl-2-n-propyl-1,3-propanediol dicarbamate.
U. S. Patent No. 2,724,720.

Conjugated Estrogens (equine)..... 0.4 mg
Licensed under U. S. Patent No. 2,429,398.

*Two-dimensional
treatment
of
the*



DOSAGE: One tablet t.i.d. in 21-day courses
with one week rest periods.
Should be adjusted to individual requirements.
Samples and literature on request.

"Milprem"

MILTOWN® + CONJUGATED ESTROGENS (EQUINE)
A Proven Tranquilizer A Proven Estrogen



WALLACE LABORATORIES, New Brunswick, N. J.

who discovered and introduced Miltown, the original meprobamate.



Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, FEB. 3, 1958



Your State Taxes: How They Compare

The typical physician in private practice grosses slightly more than \$25,000 a year, according to MEDICAL ECONOMICS' latest survey. Yet his take-home pay is only about half that much. Where does the rest go?

Well, practice-connected expenses eat up some \$9,000. Assuming the physician has a wife and two children, he pays another \$3,000 or so in Federal income taxes. And state taxes take a further small but substantial bite. Such taxes are usually levied on income, sales, gasoline, alcohol, or any combination of these and other items.

What's the state-tax burden of the typical doctor? It varies greatly depending on where he lives. To get a birds-eye view of the variations, consult the accompanying chart. In it you'll find annual estimates of income, sales, and gasoline taxes for each of the forty-eight states and the District of Columbia. (On the state level those partic-

HOW YOUR STATE TAXES COMPARE

What the Typical Doctor Pays in

State	Income Tax	Sales Tax	Gasoline Tax	Total
Alabama	\$365.60	\$210.00	\$80.43	\$656.03
Arizona	436.77	140.00	57.45	634.22
Arkansas	172.51	210.00	74.69	457.20
California	122.34	210.00	68.94	401.28
Colorado	279.61	140.00	68.94	488.55
Connecticut	None	210.00	68.94	278.94
Delaware	455.85	None	57.45	513.30
District of Columbia	269.11	140.00	68.94	478.05
Florida	None	210.00	80.43	290.43
Georgia	389.62	210.00	74.69	674.31
Idaho	794.65	None	68.94	863.59
Illinois	None	175.00	57.45	232.45
Indiana	360.24	None	68.94	429.18
Iowa	396.48	140.00	68.94	605.42
Kansas	470.85	140.00	57.45	668.30
Kentucky	889.82	None	80.43	970.25
Louisiana	194.34	140.00	80.43	414.77
Maine	None	210.00	80.43	290.43
Maryland	246.34	140.00	68.94	455.28
Massachusetts	391.05	None	63.20	454.25
Michigan	None	210.00	68.94	278.94
Minnesota	917.36	None	57.45	974.81
Mississippi	250.68	210.00	80.43	541.11
Missouri	106.48	140.00	34.47	280.95
Montana	335.60	None	80.43	416.03

Factors in State Taxes*

State	Income Tax	Sales Tax	Gasoline Tax	Total
Nebraska	None	None	\$80.43	\$ 80.43
Nevada	None	\$140.00	68.94	208.94
New Hampshire	\$ 693.77	None	57.45	751.22
New Jersey	None	None	45.96	45.96
New Mexico	162.34	140.00	68.94	371.28
New York	640.19	None	45.96	686.15
North Carolina	614.19	210.00	80.43	904.62
North Dakota	521.19	140.00	68.94	730.13
Ohio	None	210.00	57.45	267.45
Oklahoma	184.48	140.00	87.09	411.57
Oregon	775.42	None	68.94	844.36
Pennsylvania	None	210.00	57.45	267.45
Rhode Island	None	210.00	45.96	255.96
South Carolina	465.85	210.00	80.43	756.28
South Dakota	None	140.00	68.94	208.94
Tennessee	None	210.00	80.43	290.43
Texas	None	None	57.45	57.45
Utah	385.60	140.00	68.94	594.54
Vermont	1,236.28	None	74.69	1,310.97
Virginia	525.85	None	68.94	594.79
Washington	None	285.00	74.69	359.69
West Virginia	None	140.00	68.94	208.94
Wisconsin	705.10	None	68.94	774.04
Wyoming	None	140.00	57.45	197.45

*The accompanying text for the assumptions on which this chart is based.

HOW YOUR STATE TAXES COMPARE

ular taxes are the ones that really dig into your pocket.)

To arrive at these estimates, MEDICAL ECONOMICS has assumed that the taxpayer grosses \$25,000 a year, that he nets \$16,000, and that he has a wife and two children. It has also assumed that the typical doctor spends about \$7,000 annually for items on which sales taxes are commonly levied—e.g., purchases, utilities, and entertainment—and that he buys about 1,150 gallons of gas a year.

These figures indicate that although sales taxes may be a nuisance, it's the state income tax that can really hit you hard. For example, Vermont, Minnesota, and Kentucky don't levy sales taxes. Yet their income taxes bring all three states to the top

of the list. The typical Vermont doctor has to pay his state over \$1,300 in taxes. His Minnesota and Kentucky colleagues aren't far behind, with a state tax burden of nearly \$1,000 each.

By contrast, typical doctors in New Jersey, Texas, and Nebraska pay the least in state taxes. They shell out well under \$100 yearly—none of it in either income or sales tax. (The national median is a little over \$450.)

Figures in the chart indicate *current* tax levels. If past trends continue, you'll be paying still more to Albany or Sacramento or Tallahassee or whatever in the years to come. Many legislatures have raised tax rates recently. And state yields have jumped a whopping 370 per cent during the last fifteen years. ENT

Manly Ambition

I was admitting a 3-year-old boy to the pediatrics ward for a herniorrhaphy. All went well until I drew blood from his arm. Trying to make him forget both the needle and his tears, I asked: "What are you going to do when you grow up?"

He stopped crying, looked me straight in the eye, and said: "I'm going to kill you!" —JULIAN L. GLATT, M.D.



How to Make Your Phone Work for You

Let your office aide ask clinical questions, answer nonclinical ones, and make collection calls

By Boyce Morgan It's a good idea to check up occasionally on how well your aide answers the phone—and in an earlier article I suggested ways to go about it. But a telephone isn't just something to be answered. Used properly by the aide, it can save your time and actually improve your earnings. This article tells how.

Take time-saving first. How far can an aide go in eliciting clinical information from patients who call in? Well, in my observation, she's capable of going further than she actually does in most medical offices. Which means that most doctors may be wasting a certain amount of time on incoming calls.

Not Dr. Newell, though. He's a pediatrician I know, and he's trained his aide to be of maximum help to him

THE AUTHOR heads a Washington, D.C., firm of business consultants that publishes "Better Business by Telephone," a twice-monthly service devoted entirely to more effective business and professional use of the telephone. This article is the second of two on the subject. For the first, see MEDICAL ECONOMICS, Jan. 20.

MAKE YOUR PHONE WORK FOR YOU!

in getting clinical information about patients over the phone. Let's see how she does it in a typical case:

Mrs. Anderson telephones Dr. Newell about her sick child. The doctor's girl explains that he's tied up with patients but will be free to call back at a specified time. Then she adds:

"In the meantime, Mrs. Anderson, I can help if you'll tell me all Johnny's symptoms. I'll report them to Dr. Newell. Then I'll phone to tell you what to do till he can talk to you himself."

She questions Johnny's mother closely, makes careful notes and reports to the doctor at the first opportunity. If her report indicates that the illness is serious, Dr. Newell himself calls back promptly. But usually the aide makes the first return call. And sometimes she even relays all the information the mother needs to handle the situation herself.

Of course, any such questioning of a patient must be limited by your aide's knowledge and her ability to report accurately to



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KAUFMAN

"Are you finishing yesterday's calls or starting today's?"

you. Moreover, she must make it clear she's soliciting the information *for you*. She can do this by saying such things as: "Dr. Williamson will want to know . . ." and also "Can I tell Dr. Williamson . . .?"

Patients' Queries

What if questions come from the other end of the line? Here's where a well-trained aide can really help you. Though there are many telephone inquiries she shouldn't answer too specifically, she should try to offer *as much* information as she can, rather than *as little*. Business firms have proved the value of this policy in building goodwill. It can be equally effective for the physician in private practice.

For example, it's perfectly possible for your aide to answer a question about fees in general terms. She can do so without committing herself to definite figures and without misleading the patient.

If a telephone caller asks: "How much does Dr. Williamson charge for an examination?" he won't be happy if he gets some such reply as: "Oh, I couldn't possibly tell you that. It depends entirely on the nature of the

case." The following response is equally noncommittal but far more satisfying:

"Well, Mr. Crane, that naturally varies a great deal with the nature of the case. A simple physical examination without any laboratory tests or X-rays might run as little as \$—. On the other hand, it could run considerably more if special tests were required. Dr. Williamson can give you a definite figure after he knows more about your problem."

Be Approachable!

One other point in handling callers' questions: It's unwise for your secretary to overplay the fact that you're very busy and hard to see. Some girls tend to do this, perhaps because they believe they're building up their employer's reputation. But it's poor psychology from the patient's standpoint. "Who does that doctor think he is?" he's apt to mutter. "Does he think he's doing me a favor by condescending to take my money?" If your aide's telephone technique inspires that sort of reaction, it's bad business.

Another telephone technique can be very good business in-

MAKE YOUR PHONE WORK FOR YOU!

deed: the diplomatically handled collection call. It's more personal and friendly than a collection letter. Thus it's more likely to produce results.

Here's an approach that has worked well for several physicians I know. The aide makes the call and says something like this:

"Mr. Daggett? This is Miss Clark in Dr. Williamson's office. I handle Dr. Williamson's accounts for him, and he just doesn't like me ever to write a letter about a bill to one of his patients."

At this point she pauses for a moment. The patient often reacts by volunteering information without further prodding.

If he remains silent, the girl goes right on:

She Pins Him Down

"I was going over our accounts today, and I noticed that Dr. Williamson hasn't had a payment from you since last November. So I thought I'd give you a ring and see what the situation was. I was wondering whether you could arrange to make a payment now."

What she says after that depends on the patient's response.

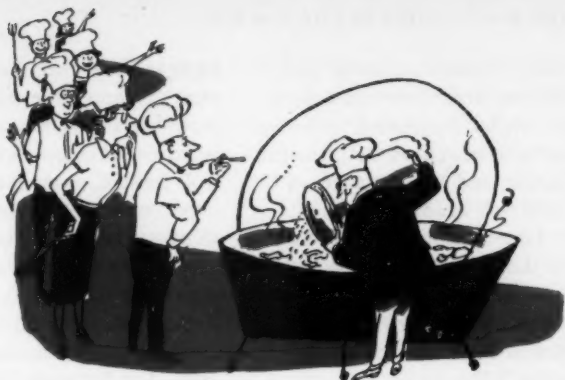
The thing she aims for is a definite commitment, even if for only a small amount. The thing she steers away from is a vague promise to "pay as soon as I can."

This approach has at least two major advantages. For one thing, *you* are kept out of it. For all the patient knows, you aren't even aware the call is being made. So he's less on the defensive and more likely to commit himself to payment.

He'll Talk to Her

At the same time, if he's harboring any sort of grudge, the secretary will find it out with a minimum of embarrassment to both the patient and you. It's a fact that patients—particularly women—are more willing to reveal the real reason for their non-payment of medical fees to the doctor's aide than to the doctor himself.

So there you are. From the first request for an appointment to the final collection of a bill, the telephone can be a potent tool in the hands of your aide. Make sure she's using it to advantage. If she is, your patients, your practice, and you will all reap the profits. END



Too Many Cooks at A.M.A. Headquarters?

*Efficiency experts find symptoms of bureaucracy,
but the A.M.A. trustees say they've got it licked*

By Robert L. Brenner

You and your colleagues pay more than \$1,300,000 in dues toward the A.M.A.'s operations each year. Have you ever wondered how efficiently this money is spent? Whether the A.M.A.'s 650-employee Chicago headquarters is at all afflicted by the bureaucratic symptoms that doctors complain about in government?

Well, according to Robert Heller & Associates, a firm of management consultants that the A.M.A. hired to study its operations, the big headquarters building at 535 North Dearborn Street *has* been suffering from a mild

TOO MANY COOKS AT THE A.M.A.?

case of bureaucratic bulge. Among many other discoveries, the Heller firm found "a number of basic weaknesses in the organization and composition" of the A.M.A.'s headquarters staff.

One such weakness is said to be that at the clerical level there are just too many people around. "There are more clerical employees than the work load warrants," the Heller report says. "It is common practice for department heads to staff their organizations with extra persons to compensate for the lack of fully competent personnel and for the leisurely work pace."

Salaries Too Low?

Why this alleged shortage of competent personnel? Because the A.M.A. pays too little, the report suggests: "A.M.A. salaries, particularly in the lower job grades, are in most instances below those prevailing in the area."

But if there are too many people at the clerical level, Heller thinks there may be too few in higher staff positions. Several A.M.A. executives are said to have had too many duties to handle them all effectively. For example:

The general manager has had

twenty-four separate departments responsible directly to him. The Heller firm thinks this is more than one person can control. Besides, a number of these departments "are not of sufficient importance or size to warrant his direct supervision," says the report.

Some department heads are similarly overburdened, the firm adds. For example, the head of the public relations department has had nine people reporting directly to him. Heller recommends that he be freed from the resulting "time-consuming detail," thus permitting him to "devote more attention to policy and administrative matters."

These are fairly typical of the "basic weaknesses" the Heller firm found at A.M.A. headquarters. Although none is really serious by itself, they add up to a potential drain on organized medicine's efficiency—and on A.M.A. members' pocketbooks.

What's the answer? A.M.A.'s delegates decided at last December's convention that its board of trustees was well aware of the problem. "After all," said one delegate at Philadelphia, "if they hadn't felt there was need for improvement, they wouldn't have

paid Heller to make the study in the first place."

Some top-level changes have already resulted. The A.M.A.'s new chief executive, Dr. F. J. L. Blasingame, will not be general manager but executive vice president. Another newly created post, secretary-treasurer, will help spread the executive burden. And more responsibilities will be assigned to a new business manager.

Lower-level changes have been left in the hands of the A.M.A. trustees. Working with Dr. Blasingame, they're expected to follow through on most of the Heller recommendations—though not all. "Nobody can study an organization of our size for just six weeks and get a true perspective of all the activities in all the departments," one trustee told this magazine.

Other trustees, too, feel that the Heller firm may have jumped to some wrong conclusions. But they're not sure, and they're counting on the A.M.A.'s new executive vice president to turn up the true facts.

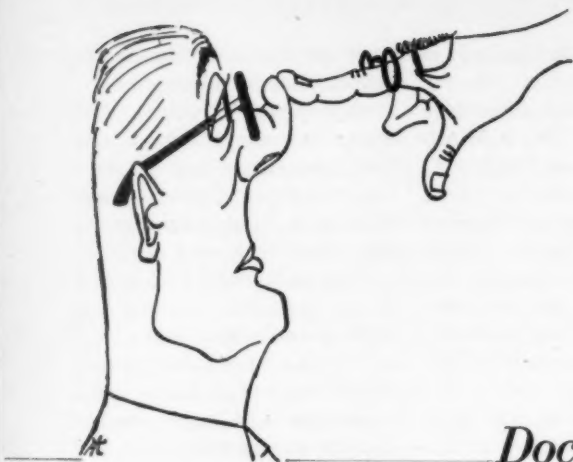
That was the consensus this magazine found a month ago when it sounded out a majority of the A.M.A. trustees. Some of

their specific comments on the points raised by Heller:

Overstaffing: "Heller's man found too many clerks in one particular place," said one trustee, "but I don't believe it's true of A.M.A. headquarters generally." Said a second trustee: "There's no thought of slicing off 20 per cent of the clerical help right down the line." But a third said: "The board recognizes there's some merit to the Heller suggestion that some clerical help be eliminated. We'll know for sure after Dr. Blasingame has had a chance to study it."

Underpaying: "Since the Heller report, we've been restudying salary levels at A.M.A. headquarters," a board member reported. "We want Dr. Blasingame to make his recommendations first. But I think the board will start doing something [about raising salaries] within the next few months."

Overburdening of executives: "The board feels there should be more dispersal of responsibility among the junior executives at A.M.A. headquarters," one trustee commented. "We've already done something about it. We'll do more if that's what Dr. Blasingame recommends." END



Doctors Talk Bo

Melvin M. Belli is the malpractice lawyer who has taken the most doctors to court. He believes that medicine's worst enemies are not lawyers like himself, but rather "your own outmoded tribal customs and the insurance companies that loom over you like Damocles' sword in every malpractice case that comes into court." He said this—and a lot more—in the October, 1957, *MEDICAL ECONOMICS*.

He maintained that most doctors won't testify against their colleagues even in cases of obvious malpractice. This, he added, is due largely to pressure from organized medicine and the insurance companies. And, citing various ways by which he has won malpractice awards of \$100,000 and up for injured patients, he said: "It's my firm conviction that these six-figure awards are equitable and necessary." He confidently predicted that the

Is medicine above the law? Melvin Belli raised that question in a recent issue. Now here's what well-informed physicians say on such subjects as six-figure court awards, reluctance to testify—and malpractice lawyers like Mr. Belli

Back to the Plaintiff's Attorney—

near future would bring "more adequate awards of \$500,000 and up."

Mr. Belli's article stirred a number of readers to anger, to argument, and to thoughtful discussion. In the following paragraphs, you'll find a representative cross-section of the comments received by this magazine in response to the article:

Melvin Belli wrote: "I see those large judgments as an indication that justice is at long last being done—that a somewhere-near-adequate price tag is belatedly being placed on human suffering caused by human error."

Says Dr. Frederick W. Knoch of Oak Park, Ill.: "How valuable suffering is when doctors cause it! How relatively cheap the same suffering is when we relieve or prevent it! My advice to Mr. Belli: Stay well—or else become exceedingly wealthy. With your high standards for

DOCTORS TALK BACK

suffering, you can hardly resent a \$10,000 bill for, say, an appendectomy."

Says Dr. Joseph F. Sadusk Jr., chairman of the A.M.A.-A.H.A. Joint Liaison Committee on Professional and Hospital Liability: "The idea of 'more adequate awards' of \$500,000 and up is appalling. The average medical malpractice premium over the entire country is probably \$100 a year. Which means it's actuarially feasible for only one in 5,000 physicians to have such a judgment against him. But in Northern California, one out of *fifty-two* doctors has a suit filed against him in any given year. Obviously, Mr. Belli's figuring is out of line."

Says Dr. Raymond G. Jacobs of Enid, Okla.: "I know one case where a man slipped and fell on a faulty stairway. He suffered a broken neck, with paralysis from the neck down. The neck fracture was reduced and pressure on the cord released, resulting in almost normal function. The surgeon's fee for accomplishing this was \$135. The lawyer's fee for winning the man a \$10,000 accident award was \$4,000. Is this what Mr. Belli means when he says justice is being done?"

Says a Shreveport (La.) physician: "I suggest that all plaintiffs institute malpractice suits against lawyers who lose their cases for them. It would be a good idea to make the sky the limit. About \$500,000 should soothe the suffering of the aggrieved plaintiff. That's plain justice, by Mr. Belli's standards."

Says Dr. Clarence A. Peckler of Chicago: "From the tenor of his article, I suspect that Mr. Belli's interest in larger awards and greater justice is based on his contingency fees of 33 to 50 per cent. Certainly, no lawyer specializing in handling plaintiffs' malpractice claims is going to be against big awards."

No \$40,000 Fees

Says Dr. Myrvin H. Ellestad of Long Beach, Calif.: "Do you really know human suffering, Mr. Belli? Have you ever worked all day or night with a man in shock or coma, knowing you'd never get a cent for it? Or watched his wife, the mother of four children, with hope in her eyes when you had little hope yourself? Have you ever worked with a woman suffering excruciating pain from cancer of the bone? Yes, Mr. Belli, we doctors

know the price of human suffering. But, unlike yourself, we haven't learned to translate it into \$40,000 fees."

Reluctance to Testify

Melvin Belli quoted approvingly a California jurist who said: "The so-called ethical practitioner will not testify on behalf of the plaintiff, regardless of the merits of the case. This is largely due to pressure exerted by medical societies and public liability

insurance companies . . . The plaintiff is relegated, for his expert testimony, to the occasional lone wolf or heroic soul who . . . has the courage to run the risk of ostracism by his fellow practitioners and the cancellation of his public liability insurance policy . . ."

Says Dr. Herbert Berger, president of the First District (New York City) of the Medical Society of the State of New York: "I've seen [MORE ON 184]



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"It's a Dr. Jones, Miss—something about a rabbit test."

Is Social Security A Good Buy?

It's fundamentally different from private insurance. Nevertheless, some cost-and-coverage comparisons can be made. Here's must reading

By Albon P. Man Jr., LL.B.

EDITOR'S NOTE: "The burning question of Social Security still confronts the physicians of the United States . . ." So said a resolution that Connecticut doctors introduced last year in the A.M.A. House of Delegates. This year the burning question may get even hotter. Three bills to extend Social Security so as to include self-employed M.D.s are now before the House Ways and Means Committee.

You've heard all shades of *opinion* on this issue. MEDICAL ECONOMICS recently summed them up in two articles, pro (October, 1957) and con (August, 1957). The big need now is for *facts*.

Months ago, this magazine commissioned an impartial analyst to make a factual study of how Social Security compares with private insurance in terms of cost, coverage, exclusions, etc. The analyst, Albon P. Man Jr., is an attorney associated with the tax and insurance publi-



cations of Prentice-Hall, Inc. The accompanying article is his detailed report.

We believe it's as unbiased a report as you'll find on the subject. It does *not* deal with the moral, philosophical, or political aspects of Social Security, which have been well covered in these pages. It deals only with economic facts.

Use it to crystallize your own thoughts on Social Security. The chips are down—and the choice is up to you.

When physicians argue the pros and cons of Social Security, someone is sure to say: "You can do just as well or better buying private insurance policies with the money you'd have to pay in Social Security taxes."

Is this true? Judge for yourself from the facts presented in this article.

First, we'll take a look at the three types of protection

IS SOCIAL SECURITY A GOOD BUY?

you and your family would get if self-employed M.D.s came under Social Security. Then we'll estimate what such protection would cost you in Social Security taxes.

Next, we'll examine some comparable private insurance policies—ones that offer similar protection. We'll analyze them, too, in terms of both benefits and costs.

Finally, we'll see how the two kinds of coverage stack up against—or might supplement—each other. And we'll make the

comparison as objective as possible, balancing only the economic facts and keeping matters of opinion out of it.

Benjamin B. Kendrick, Social Security expert of the Life Insurance Association of America, says that Social Security "can be considered a good buy, with the participants on the whole getting their money's worth." After pondering the facts in this article, you may agree with him. If you disagree, you'll at least have a solid statistical background on which to base your opinion.

What You'd Get From Social Security

Three types of monthly benefits would be available to you and your family if self-employed M.D.s were covered by Social Security:

1. *Survivor benefits*—for your wife and children if you died before your youngest child was 18:

2. *Retirement benefits*—for you and your wife if you stopped practicing at 65 or later; and

3. *Disability benefits*—for you alone if you were 50 or over and permanently and totally disabled.

In describing each of the

above, we'll take it for granted you're earning at least \$4,200 a year from your medical practice. This is the maximum taken into account for Social Security tax purposes. And since benefit amounts are based on earnings, annual earnings of \$4,200 or over would produce the highest possible benefits. These are:

1. *Survivor benefits*: If you died and left your wife and one child under 18, they'd get benefits totaling \$162.80 a month until the child reached 18. Then the

benefits would stop. If your wife remarried before that time, only the child would get benefits—of \$81.40 a month.

If you died and left your wife and two or more children under 18, they'd get benefits of \$200 a month until only one child remained under 18. Then benefits would drop to \$162.80 a month; and they'd stop when this youngest child reached 18. Total benefits paid over the years while your wife was raising the children could exceed \$42,000 if you died when they were very young.

Your wife would be without

benefits from the time your youngest child reached 18 until she was 62. From then on she'd get \$81.40 a month for life, provided she didn't remarry.

Note that your family would get the above survivor benefits upon your death *at any age*. For instance, if your first child were born when you were 30 and your last when you were 48, your family would be protected for a total of 36 years. And you wouldn't have to pay higher taxes at later ages for such protection. Nor would you need to take a medical examination to make sure you were a good risk. MORE ►



"Well, her history is complete—now to get down to her geography."

IS SOCIAL SECURITY A GOOD BUY?

Incidentally, your wife would also get a lump-sum benefit of \$255 upon your death. But because this is so small, we'll ignore it in our later comparison of Social Security with private insurance.

2. *Retirement benefits:* On retiring at 65 or later, you'd get \$108.50 a month for life; and your wife would get an additional \$54.30, provided she was also over 65. At your death, your wife's benefit would go up to \$81.40. This would continue until she died or remarried.

Thus you and your wife—if she's about your age—could look forward to retirement benefits that might total more than \$30,000 if you lived into your 80s.

If your wife were between 62 and 65 when you retired, she could elect to take a smaller

monthly benefit starting immediately, rather than wait until 65 for her full \$54.30. But this monthly sum would *not* then be increased when she reached 65. However, the choice wouldn't affect her right to \$81.40 a month after your death. (The amount payable to a wife at 62 is three-quarters of the amount she'd get by waiting till 65. The proportion increases the longer she delays.)

3. *Disability benefits:* If you were permanently and totally disabled and at least 50 years old, you'd get monthly benefits of \$108.50 for life, after an initial waiting period of six months. No benefits would be payable for your family until you reached 65. At that time, the regular retirement provisions described above would come into effect.

What You'd Pay for Social Security

How much would you pay for the three kinds of protection you'd get under Social Security?

The table on page 89 shows total Social Security taxes self-employed physicians of various ages would pay if they came under the

Act as of Jan. 1, 1959, and if they continued to earn at least \$4,200 a year until age 68. (Why 68? Because most men under Social Security retire around that age. They don't stop working at the age of 65.)

The table also shows the average annual tax you'd have to pay. Figures are based on the yearly Social Security tax rates for the self-employed as set by Congress in 1956: 3 3/8 per cent (\$141.75 a year) for 1959; 4 1/8 per cent (\$173.25) for 1960-64; 4 7/8 per cent (\$204.75) for 1965-69; 5 5/8 per cent (\$236.25) for 1970-74; and 6 3/8 per cent (\$267.75) thereafter.

Age as of Jan. 1, 1959	Total Taxes Payable to Age 68	Average Annual Social Security Taxes
30	\$9,103.50	\$239.57
35	7,764.75	235.30
40	6,426.00	229.50
45	5,087.25	221.18
50	3,748.50	208.25
55	2,504.25	192.63
60	1,417.50	177.19

Of course, the above figures are somewhat tentative: Congress can always step up Social Security tax rates in the future, just as it has done in the past. But remember that whenever

Congress has raised the rates, it has at the same time broadened the benefits. So if the figures in the above table are ever forced upward, our later figures on the cost of private insurance policies offering comparable protection are also likely to be forced upward.

Less of a Buy Later

And one further thing to note: The table assumes you'd come under Social Security on Jan. 1, 1959. Men who began practice at later dates would have to pay higher tax rates. For example, a doctor starting off in 1975 would pay the top tax rate of 6 3/8 per cent a year—\$267.75—from the outset. So his Social Security taxes between his thirtieth and sixty-eighth birthdays would total \$10,174.50.

Naturally this would make Social Security less of a buy for tomorrow's doctor than for the man now in practice.

The Cost of Comparable Insurance

In many ways it's like comparing apples with oranges to compare Social Security with private

insurance. Life insurance companies simply don't wrap up in one policy the three types of pro-

IS SOCIAL SECURITY A GOOD BUY?

tection provided by Social Security.

For the nearest thing to Social Security survivor benefits, you'd buy what's generally known as a reducing term insurance policy. For an approximation of Social Security retirement benefits, you'd pick an annuity policy. And for a rough equivalent of Social Security disability benefits, you'd buy a health-and-accident policy.

Virtues and Defects

No combination of these policies would give you and your family exactly the same kinds of protection as Social Security. And they all have certain virtues and defects when compared with it. Let's consider each type in turn:

1. *Reducing term insurance:* Such a policy will meet the needs of the man who's raising a family and wants to make sure his wife will get some money every month after his death until his children have grown up. One insurance company that has designed a contract especially for this purpose calls it a "family security" policy. We'll use that name for convenience.

In the family security policy,

the insurance company promises that if you die within a certain period of years after the policy is issued, it will pay a monthly sum to your beneficiary for the unexpired part of the period.

Family Security

The first table on the opposite page shows the premium charges at various ages for an eighteen-year family security policy paying \$200 a month. (Why eighteen years? Because that's the longest time your widow could receive Social Security survivor benefits while raising your children. Why \$200 a month? Because that's the most your widow and children could get under Social Security.)

Let's say you have this particular family security policy with your wife as beneficiary. If you die after one year, the company will pay her \$200 every month for seventeen years—a total of \$40,800. If, on the other hand, you die after sixteen years she'll get the \$200 a month for only two years—a total of \$4,800.

After you've paid premiums for fourteen years on this particular kind of reducing term insurance (which can't generally be

bought if you're over 52), you're paid up for the remaining four years. So while you're protected for *eighteen* years, your total cost is only *fourteen* times the annual premium.

Age at Issuance	Annual Premium	Total Premiums Payable During Protection Period
30	\$136.40	\$1,909.60
35	164.00	2,296.00
40	220.20	3,544.80
45	316.80	4,435.00
50	471.60	6,602.40

We'll use the above figures for purposes of comparison with Social Security in all our later computations. But it *is* possible to buy the same coverage at lower cost through a so-called "family income rider." This is an endorsement or addition to one of the basic types of insurance pol-

icy (such as a straight life or a twenty-year endowment contract).

The hitch is that most insurance companies won't sell you a rider that will pay \$200 a month unless you buy a \$20,000 basic policy at the same time. Thus you have to pay regular premiums for the basic coverage you're *required* to buy as well as extra premiums for the family income rider.

Shown below are representative premiums for one company's \$20,000 straight life policy, including a twenty-year family income rider providing \$200 a month.*

Thus, if you're 30 years old

*This insurance company, like many others, won't sell a twenty-year rider to a man over 50.

Straight Life With Family Income Rider

Age at Issuance	Annual Premium For Straight Life Policy	Extra Premium For Family Income Rider	Total Annual Premium
30	\$361.20	\$109.20	\$ 470.40
35	425.00	138.60	563.60
40	508.20	193.60	701.80
45	616.40	283.20	899.60
50	757.00	423.60	1,180.60

IS SOCIAL SECURITY A GOOD BUY?

and want a twenty-year family income rider paying \$200 a month on your death, you'll have to pay at least \$470.40 a year for sixteen years. (With the sixteenth annual premium, the rider is paid up.) And after the sixteenth year, you must continue to pay an annual \$361.20 for the basic coverage.

Endowment Method

The premium at age 30 for the same company's endowment policy paying \$20,000 at 65 is much higher—\$503 a year. The cost of the family income rider brings the premium up to \$612.20.

Don't forget that you have to pass a physical exam in order to get any of the above private insurance coverage. And the coverage becomes more and more costly to buy as you grow older.

2. *Annuities:* Retirement benefits for your wife and yourself are the most expensive feature of Social Security to duplicate in an insurance policy. Critics of Social Security for physicians often overlook this fact.

Their Argument

"Look," say some critics: "If you're 30 years old, your Social Security tax would average

\$239.57 a year over the next thirty-eight years, assuming you retired at 68. But you can get a family security policy offering comparable survivor benefits for only \$136.40 a year."

What they forget is that the 30-year-old doctor who also wants the same *retirement* benefits as Social Security—and who has, say, a 27-year-old wife—must buy an annuity policy at an extra cost of at least \$346.84 a year until he's 68.

A Fair Comparison

So it seems more accurate to compare his average yearly Social Security tax with the average yearly *total* of his family security, annuity, and disability premiums, if they were spread out evenly over the next thirty-eight years.

This latter average annual total for private insurance would amount to \$451.50, as against the \$239.57 annual average total for Social Security, in the case of the 30-year-old doctor.

The following table shows sample premiums doctors at various ages would pay if they bought annuity policies providing the same retirement benefits as Social Security. (It's assumed here

that the doctor is three years older than his wife.)

Age at Insurance	Annual Premium	Total Premiums Payable to Age 68
30	\$ 346.84	\$13,179.92
35	442.76	14,611.08
40	577.15	16,160.20
45	775.28	17,831.44
50	1,090.51	19,629.18
55	1,658.09	21,555.17
60	2,951.75	23,614.00

Two qualifications about the above figures for private insurance retirement benefits compar-

able to Social Security benefits: First, the table is based on the assumption that both you and your wife would get Social Security benefits when you retired. But one out of four men reaching retirement age is single or a widower. In any such case, the cost of duplicating Social Security benefits would obviously be lower.

Second, the kind of private annuity we've mentioned would pay a lump-sum benefit to your family if you were to die before



"Relax—I've never yet heard of lightning hitting a bedpan."

IS SOCIAL SECURITY A GOOD BUY?

retirement age. If you died in your 60s, this benefit would be almost as large as the premium cost. On the other hand, the maximum Social Security death benefit is only \$255. So there's a greater element of risk in Social Security coverage than in its private equivalent.

3. *Health-and-accident insurance*: As for a private insurance policy paying disability benefits comparable to those of Social Security, there's this to remember: You could get such benefits under Social Security only if you were permanently and totally disabled *and at least 50 years old*. So there's no point in discussing the premiums that a man under 50 must pay for a private disability policy.

Here you run into the apples vs. oranges problem again: No private company sells a policy with *exactly* the same provisions as the disability benefit provisions of the Social Security Act. But for a rough comparison, let's consider a popular policy of a well-known mutual life insurance company.

This policy is sold to men who aren't more than 55 years old and who can pass a medical exam. If you're totally disabled in

an accident, it pays you a monthly income for the duration of the disability, after a three-month waiting period. If you're totally disabled from disease, it pays you a monthly income (full rate for three years, half-rate for the remaining years) until the disability ends or you're 65, whichever comes first. It also pays certain benefits upon accidental death or loss of limb, and upon partial disability due to an accident.

Here are figures on what the policy will cost a man who takes it out at age 50 or 55, who wants \$108.50 a month in benefits (the Social Security maximum), and who keeps on paying premiums until he reaches 65:

Age at Issuance	Annual Premium	Total Premiums To Age 65
50	\$137.84	\$2,067.60
55	158.17	1,581.70

It's possible to get group health-and-accident insurance through many medical societies. This costs much less—typically, around \$50 a year (no matter what your age) for benefits of \$108.50 a month. But the typical group policy pays benefits for only five years. So it cannot be compared with the longer-

paying individual policy described above. Nor can the group policy be compared with Social Security.

Even the individual policy is only roughly comparable. It

matches Social Security's disability protection—and offers some side benefits too. There's no way to take these "extras" into account in our subsequent cost comparisons.

How They Compare in Price

You've seen what you'd pay in taxes for Social Security. You've seen what you'd pay in premiums for insurance policies giving you roughly equivalent protection. How do the two sets of figures compare when you put them side by side?

The table below tells the story. To get the answer at a glance, look along the line for the age nearest your own. For example, suppose you're 40:

At this age, the premiums for insurance policies giving you pretty much the same protection

Comparable Policies vs. Social Security

Age	Average Annual Premiums	Average Annual Social Security Taxes	Total Premiums Payable During Protection Period	Total Social Security Taxes Payable to Age 68
30	\$451.50	\$239.57	\$17,157.12	\$9,103.50
35	574.99	235.30	18,974.68	7,764.75
40	777.59	229.50	21,772.60	6,426.00
45	1,058.00	221.18	24,334.04	5,087.25
50	1,572.18	208.25	28,299.18	3,748.50
55*	1,779.76	192.63	23,136.87	2,504.25
60*	2,951.75	177.19	23,614.00	1,417.50

*No family security policy procurable after age 50 and no private health-and-accident coverage procurable after age 55.

IS SOCIAL SECURITY A GOOD BUY?

as Social Security would amount to about \$777.59 a year if averaged over the remaining years of your working life.

At this same age, 40, your average annual Social Security tax (if Congress were to bring you under the Act as of Jan. 1, 1959) would be \$229.50.

And so on, through the columns showing how your *total* payments would compare.

The table shows that the older

you were, the bigger the break you'd get if you had Social Security. The average annual insurance premiums of a doctor who's only 30 on Jan. 1, 1959, would be nearly twice his average annual Social Security taxes over the next thirty-eight years. But the average insurance premiums of a man of 60 would be seventeen times his average Social Security taxes over the next eight years.

How They Compare in Other Respects

Apart from its direct price advantage, Social Security has some real economic disadvantages in comparison with private insurance. For instance, when you take out family security or disability coverage, your protection starts right away. But if you were brought under Social Security, you'd have to continue practicing for at least a year and a half before becoming eligible for most benefits.

Another thing about Social Security: It limits the amount a person receiving benefits is allowed to earn.

If your wife went back to work

after your death, any income she got under a family security policy would continue no matter how much money she made. But if she were less than 72 years old, she couldn't earn more than \$1,200 a year without losing at least some Social Security benefits. The reason: Every Social Security beneficiary who's under 72 must forfeit one month's benefit for every \$80 (or fraction of \$80) that he earns in excess of \$1,200.*

The limitation doesn't apply, though, to persons 72 or older,

*Though he doesn't lose out on monthly payments for any month when he earns no more than \$80.

or to income other than earnings from employment or self-employment.

There's still another economic disadvantage to Social Security, and that's its rigidity.

Private insurance companies offer a wide variety of policies, from which you can pick the ones that suit your needs. For instance, if you're a bachelor, you'll very likely want the largest possible retirement annuity; but you'll have no use for a family security policy. So you'll simply buy the first and not the second.

You can't pick and choose under Social Security. Nor can you borrow against policy reserves in an emergency. You can't even cash in the insurance, as you can with private policies.

In sum, Social Security provides certain kinds of protection regardless of your special needs. You must take the whole package as it is. And it's a package with a lot of holes in it.

These economic disadvantages didn't keep self-employed dentists and lawyers from wanting it. And, like many of them, you



"Don't accept a lollipop. Keep hollering till he gives you a quarter."

IS SOCIAL SECURITY A GOOD BUY?

may already have a small stake in Social Security.

For one thing, you've been credited with earnings of \$160 a month for any time you spent in the Armed Forces between Sept. 15, 1940, and Jan. 1, 1957. This is true even though you paid no Social Security taxes in the service.

In fact, it's estimated that 35 per cent of all doctors in private practice have at least some earnings to their credit under Social Security. You may have had a job covered by the Act before you entered private practice. Or

you may have some part-time employment right now that gives you Social Security credit.

No such coverage can replace private insurance in your planning for your own and your family's future, since maximum Social Security benefits cover only a small part of most people's living costs. But Social Security *can* be a foundation for (or a supplement to) a well-rounded insurance program.

There you have the plain economic facts. How you fit them into your thinking about Social Security is now up to you. **END**

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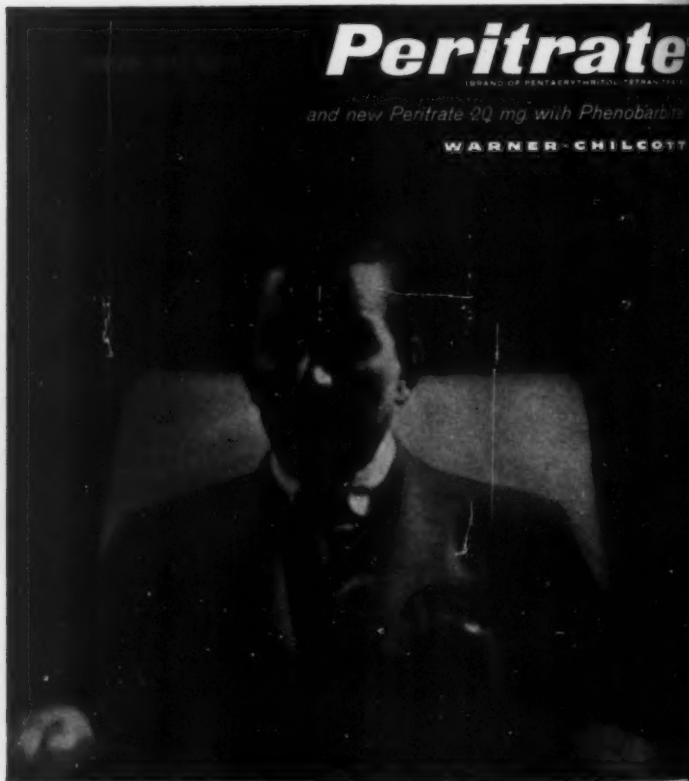
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No Surgery For Tomorrow's G.P.!

This man is training future G.P.s to concentrate on medicine instead. They'll leave surgery to the surgeons—but not much room for internists

By Max Cheplove, M.D.

I'm a member of a dying race—the G.P.-surgeons. There'll be a handful of us practicing in remote communities until helicopters become more common. But we're headed for extinction.

Am I shedding tears about it? Not at all. Though my kind of G.P. is obsolete, I think I know what the *new* general practitioner will be like. And I'm already working for his future.

Tomorrow's G.P. will probably never pick up a scalpel, except perhaps to lance an occasional boil. But he'll know internal medicine inside out. Which implies, of course, that there'll soon be an end to the G.P.'s running battle with the surgeons. His coming conflict—if any—

THE AUTHOR, who heads the General Practice Section of Millard Fillmore Hospital in Buffalo, N.Y., is also the upcoming president of the Erie County Medical Society.

NO SURGERY FOR TOMORROW'S G.P.!

will be concerned with the internists.

I'll say more about this conflict later. First I want to explain what's behind my prediction:

When I began practice in 1927, we general practitioners weren't well regarded within the profession. Some looked upon us as incompetent pill-pushers. Others felt we were dabblers in all branches of medicine and masters of none.

In recent years we've made progress in restoring our prestige with other doctors. But we haven't yet made clear what

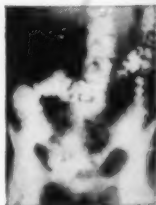
branches of medicine properly come within the modern G.P.'s sphere.

I believe it's time for us to think through our position again, to develop a sound working philosophy, and to move forward as that philosophy dictates. That's precisely what we've been doing in my community: The G.P.s at Millard Fillmore Hospital in Buffalo, N. Y., have been charting a course for the future—and we think it's going to work out.

Back in 1950, our hospital had about thirty general practitioners on the staff. We were a

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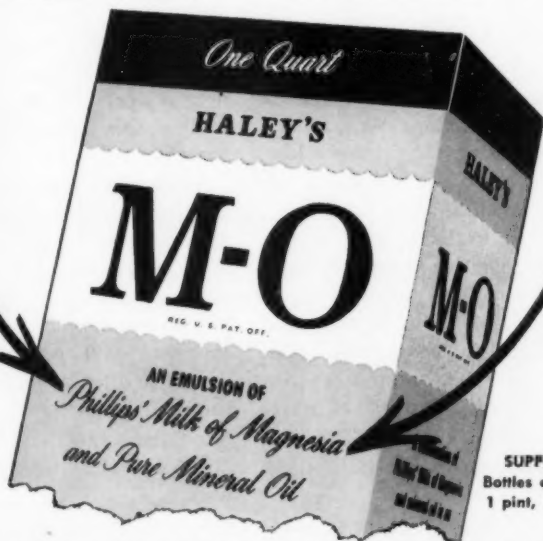
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small minority group in a teaching institution whose heads of departments were all faculty men. But we were treated very fairly. Almost all of us were on the attending staff, and we all had privileges on one or more services. I myself was a member of the surgical section.

Even so, we were holdovers and we knew it. Young G.P.s in their twenties and thirties could no longer get the privileges we older men had. The handwriting on the wall was there for anyone to see. It wouldn't affect all of us personally. But it would affect our *kind* of doctor.

No 'Last-Ditch Battle'

So two of us G.P.s — Dr. Pierce Taylor and I—did some serious thinking. We decided there was no use fighting a last-ditch battle for surgical privileges when, in good conscience, we had to admit that a man needs intensive systematic training for modern surgery.

Some of us, to be sure, had managed to get quite a lot of training in bits and patches. But was it enough to justify us in trying to insist on the G.P.'s right to do surgery? We didn't think so.

On the other hand, there were some rights we felt justified in maintaining. Among them: the right of a family physician to put his patients in the hospital; his right to grow and learn by being part of a hospital staff; and his right to have a voice in discussions and decisions on the hospital's medical policies.

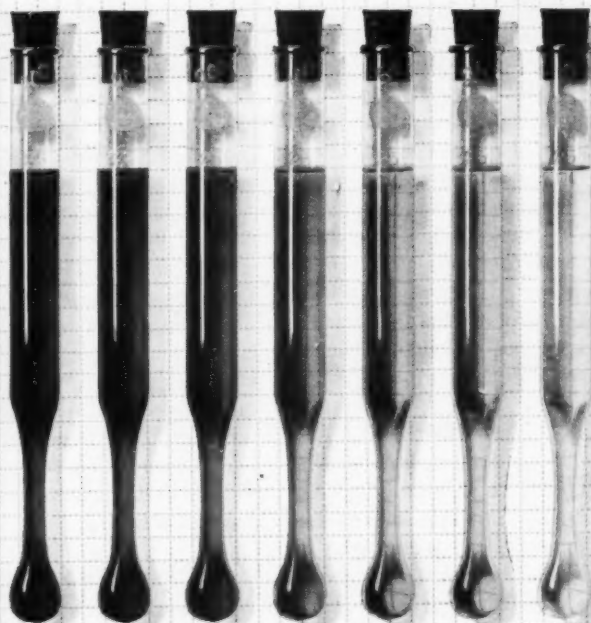
Fair Trade

So we did some horse-trading. We gave up what we considered an indefensible hold on surgical privileges. And we gained for ourselves a general practice section whose chief is on a par with the chiefs of surgery, OB/Gyn., and every other major department. In addition, we gained the right to work and advance in the medical, OB/Gyn., and pediatric services.

We couldn't have got that last advantage if the chiefs of the three services had been opposed to it. They're all board men and professors. You might suspect they'd have the kind of specialty snobbism that general practitioners so often complain about. But you'd be wrong. They recognized that what we asked for dovetails with what patients want.

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NO SURGERY FOR TOMORROW'S G.P.!

Patients want a doctor to take charge when they're sick. They'd rather not have to stop and think: "Whom do I call? My surgeon? My chest man? My cardiologist?" Understanding this fact, the chiefs of the services at our hospital have been willing to give us the hospital authority we need in order to be good family doctors.

In return for such recognition, we've been doing everything possible to maintain our reputation for competent work—and for prompt referral to specialists in cases beyond our area of competence.

Self-Confident

But we don't believe the G.P. should have an inferiority complex. He shouldn't shirk the responsibility of dealing with all the cases he can treat properly. He shouldn't refer everything to specialists. He should develop his skills, not resign himself to being second-rate.

To keep our skills sharp, we emphasize post-graduate work. We know that the G.P. has a wider range of material to keep abreast of than has the specialist. So we've organized an annual twelve-week-long symposium

for the generalists at Millard Fillmore.

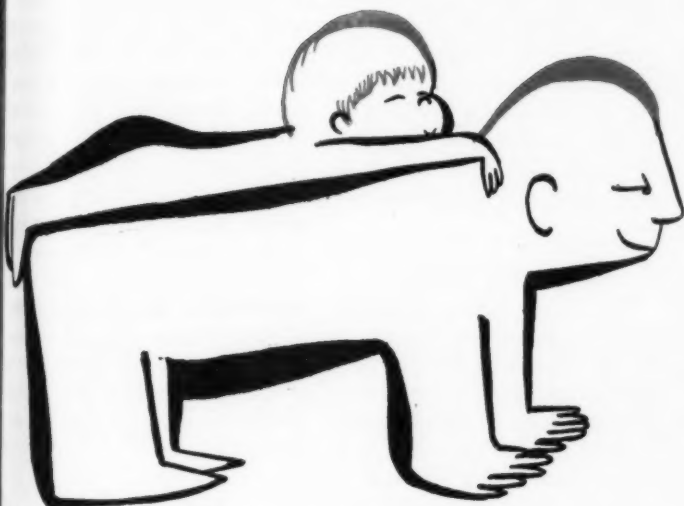
At first, our courses were pretty elementary. But they've grown increasingly advanced. This year, for example, three University of Buffalo men are offering us a course in electrocardiography that no medical center in the country would be ashamed of.

The American Academy of General Practice allows us formal credit for our symposiums. Even more important to us is the fact that our specialist colleagues know what kind of training we're getting. We've earned their respect and trust. So we're not likely to be asked to give up our coronary cases, for example, as soon as our patients reach the hospital door.

The New Generation

So much for us who are already in practice. What are we doing about tomorrow's family doctors?

The answer: plenty. First of all, we have three two-year general practice residencies that emphasize medicine, pediatrics and obstetrics. We also try to give our residents a glimpse of surgery, orthopedics, pathology,



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radiology, dermatology, ENT, gynecology, and urology. But we don't try to teach them any more than the most elementary surgical techniques. Our residents are able to sew up a wound or to diagnose a hot appendix. They don't generally learn to do such procedures as bladders and hernias.

Emergency Training

We make exceptions to the rule, of course. For instance, if a man expects to practice in a remote hamlet somewhere, we make sure he learns to do the kind of surgery that can't wait. He has to be able to take care of an appendix, an incarcerated hernia, a bowel obstruction, a fracture. But if he's going to practice in a town that has access to trained surgeons, we don't waste time teaching him surgical techniques.

Preceptorships Too

During the last two months of their residencies, our young men work directly with a G.P. preceptor. They keep office hours with him, visit the hospital with him, go on house calls with him. It's a lot of trouble for the older man—but it's worth it.

From this group of young residents come most of the additions to our staff in the general practice section. We also try to train at least one resident from out of town who'll go back to preach the gospel in another community.

We can't help feeling it *is* the gospel. We're convinced that our kind of general practitioner is the G.P. of the future. He must expect stiff competition from the family internist—but we believe that the logic is all on the G.P.'s side. Why? Because the family internist is trying to eat his cake and have it, too.

True Specialists?

He wants to be known professionally as a specialist. But if he *really* advocated specialization, he'd refer his blood problems to a hematologist, his heart cases to a cardiologist, his GI cases to a gastroenterologist, his diabetics to an endocrinologist, and so on. Naturally, he does nothing of the sort. Although he calls himself an internist, he actually practices general medicine.

I believe his is an untenable position. He believes that the significant difference between him and the G.P. is that *he* is

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certified. But the true difference, as I see it, is that the internist doesn't give complete family care. There'd be a surer place for him in medicine if he'd learn some obstetrics and pediatrics and become a *real* family doctor.

The general practitioner, as we're training him at Millard Fillmore, is already a real family doctor. He learns as much general medicine as possible. And he also learns how to lance a boil, deliver a baby, and take

care of measles. There are no artificial limits that keep him from taking full care of mother, father, grandparents, and children—up to the point where they need a specialist.

Obviously, there's going to be a jurisdictional clash between such a doctor and the family internist. One or the other will have to give way. If more training centers follow the Millard Fillmore pattern, it's the G.P. who'll survive.

END



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TABLETS

SUSPENSION

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to neutralize,
not penalize

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because

it is

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30 Ways to Cut Your Income Taxes

*You can enjoy real tax savings if you deduct
all the law allows—and it allows plenty—
in these thirty practice-connected categories*

By John C. Post

When you figure out how much to deduct for professional expenses on your next Federal income tax return, you'll probably concentrate on the big items like salaries, depreciation, and rent.

That's as it should be. But in the process, don't overlook the twenty-seven other varieties of business deductions you're entitled to. They can add up to thousands of dollars' worth of deductions. Which in turn can mean hundreds of dollars' worth of income taxes saved.

The following list describes the types of professional

THE AUTHOR, a tax and medical management consultant in Washington, D.C., heads the firm Professional Business Management, Inc.

HOW TO CUT YOUR INCOME TAXES

deductions currently allowed by the Internal Revenue Service. They're listed in alphabetical order for your convenience. Have you been overlooking any of them? It will pay you to check through the list right now—and then again at the time you sit down to fill out your final Federal income tax return for the year 1957.

Accounting Amounts you paid for services connected with book-keeping, auditing, and preparation of tax returns and tax estimates during the 1957 tax year.

Automobile Full operating cost if your automobile is used only for professional calls or if its other use is inconsequential. No part of cost if you use it solely for nonprofessional purposes or for transportation between home and office. Proportionate cost if only part of its use is for nonprofessional purposes or commuting. When permitted as a business deduction, automobile upkeep includes auto club dues; chauffeur's salary and uniform; depreciation; garage rent; gasoline; inspection fees; insurance premiums (fire, theft, collision,

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HOW TO CUT YOUR INCOME TAXES

liability, etc.); license fees; loss or damage not covered by insurance; loss on actual sale of automobile, with depreciation considered; lubrication; oil; repairs; tires and tire repairs; tolls; towing and parking charges.

Bad Debts Arising from services performed—but only if previously reported as taxable income. Remember that you must claim the deduction for the year in which the debt became worthless.

Clubs Dues and expenses if they're necessary for maintaining your business or professional contacts. Payments to service clubs and chambers of commerce are deductible if membership in such organizations benefits you in a professional way. (Itemize amounts, name organizations, and be prepared to prove benefits.)

Collections Expenses incurred in collecting your professional accounts—attorneys' fees included—assuming you report as income the gross amount collected.

Conventions Cost of transporta-

tion to and from out-of-town medical meetings. Deduct expenses such as registration fees, cost of rooms, meals, tips, etc.

Credit Bureau Fees Expenses incurred in connection with credit reports that are used in your practice.

Depreciation On all your professional property, including automobile, instruments, equipment, furniture, fixtures, permanent improvements (including leasehold improvements), or on any asset having a useful life of more than one year.

Entertainment Meals, drinks, theatre tickets, admission to games, transportation, and similar costs if they're "ordinary" and "necessary" to your practice. Be prepared to prove their practice-connection. And remember that any such expense attributable to you or your family is deductible only to the extent it exceeds what you'd ordinarily have spent.

Equipment Books, instruments, and equipment used in your practice and having a useful life estimated at one year or

Alseroxylon less toxic than reserpine

"...alseroxylon is an antihypertensive agent of equal therapeutic efficacy to reserpine in the treatment of hypertension, but with significantly less toxicity."

Ford, R.V., and Moyer, J.H.: Rauwolfia Toxicity in the Treatment of Hypertension: Some Observations on Comparative Toxicity of Reserpine, a Single Alkaloid, and Alseroxylon, a Compound Containing Multiple Alkaloids, *Postgrad. Med.*, January, 1958.



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When more potent drugs are needed, prescribe

Rauwiloid® + Veriloid®

alseroxylon 1 mg. and elixavervir 3 mg.

for moderate to severe hypertension.

Initial dose 1 tablet t.i.d., p.c.

Rauwiloid® + Hexamethonium

alseroxylon 1 mg. and hexamethonium chloride dihydrate 250 mg.

in severe, otherwise intractable hypertension.

Initial dose ½ tablet q.i.d.

Both combinations in convenient single-tablet form.

HOW TO CUT YOUR INCOME TAXES

less; also rental of equipment necessary to your practice.

Gifts If ordinary and necessary to your practice and if the benefits can be proved.

Insurance Premiums on policies covering your office or employees or otherwise related to your profession—e.g., burglary, compensation, fire, storm, theft, public liability, or professional liability insurance; also indemnity bonds on office employees.

Interest On practice-connected loans and mortgages. With installment contracts where the interest rate is not specifically stated, you may deduct 6 per cent of the average monthly balance during the taxable year (but not more than the carrying charge itself).

Journals and Books If estimated to have a useful life of one year or less. Most medical journals and medical books are in this category. While a set of books costing \$100 probably would not be allowed as a current expense, yearly depreciation on such books would be allowed.

Legal Litigation expenses connected with your medical practice.

Licenses Physician's annual license fee.

Losses Losses not covered by insurance (or in excess of insurance collected) that result from theft of or damage to business property caused by fire or acts of nature; damages paid as a result of civil suits against you arising out of your profession; business bad debts.

Maintenance All maintenance expenses of a building used entirely as your medical office. Proportionate cost if part is used for your office, part for your home. Maintenance includes such items as decorating, depreciation, heat, light, painting, repairs, water. Under this heading, include also wages paid to janitors and elevator men, and payroll taxes.

Medical Society Dues Also assessments levied by any professional society you belong to.

Moving Such expenses if the move is connected with a continuing practice. MORE▶

when you
treat infections
in patients
such as these

- debilitated
- elderly
- diabetics
- infants, especially prematures
- those on corticoids
- those who developed moniliasis on previous broad-spectrum therapy
- patients on prolonged and/or high antibiotic dosage
- women—especially if pregnant or diabetic

the best broad-spectrum antibiotic to use is

MYSTECLIN-V

Squibb Tetracycline Phosphate Complex (Sumycin) and Nystatin (Mycostatin)

Sumycin plus Mycostatin

for practical purposes, Mysteclin-V is sodium-free

for "built-in" safety, Mysteclin-V combines:

1. Tetracycline phosphate complex (Sumycin) for superior initial tetracycline blood levels, assuring fast transport of adequate tetracycline to the infection site.
2. Mycostatin—the first safe antifungal antibiotic—for its specific antimonilial activity. Mycostatin protects many patients (see above) who are particularly prone to monilial complications when on broad-spectrum therapy.

Capsules (250 mg./250,000 u.), bottles of 16 and 100. Half-Strength Capsules (125 mg./125,000 u.), bottles of 16 and 100. Suspension (125 mg./125,000 u.), 2 oz. bottles. Pediatric Drops (100 mg./100,000 u. per cc.), 10 cc. dropper bottles.

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*MYSTECLIN® *MYCOSTATIN® AND *SUMYCIN® ARE SQUIBB TRADEMARKS

HOW TO CUT YOUR INCOME TAXES

Refresher Courses The cost of post-graduate study *if* it's of direct help to you in your present practice. The course must enable you to do your current work more efficiently—not to shift to a new professional status (from G.P. to specialist, say).

Rent If paid for office quarters or professional equipment. When only part of a rented building is used for professional purposes, only a proportionate part of the

rent paid for it is deductible.

Repairs The expense of office repairs, including decorating, painting, patching, and making any alteration other than a permanent improvement; putting property in safe operating condition; repairs made necessary by an explosion, fire, or hurricane (not including capital restoration). Also deductible are repairs to medical and business equipment. MORE▶

Those Nonprofessional Expenses

Note that the checklist of deductions printed here covers only the *professional* expenses you can claim on your Federal income tax return. Don't forget that elsewhere on Form 1040 you're also allowed to deduct a number of nonprofessional expenses.

Among the more important of these are casualty losses on nonbusiness property; charitable contributions; legal fees in connection with the production or maintenance of income; expenses of maintaining rented-out property; losses resulting from sales of capital assets; interest payments; qualifying medical expenses; and many state and local taxes (real estate, income, personal property, auto license, sales, gasoline, and—in some states—cigarette and liquor taxes).

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freedom from asthma

...thanks to Tedral prescribed by his physician.

*No single drug can equal Tedral to protect
the asthmatic patient against symptoms
'round the clock.*

Dosage: 1 or 2 tablets q.i.d.

Available: boxes of 24, 120 and 1,000.

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HOW TO CUT YOUR INCOME TAXES

Salaries Paid to secretaries, nurses, technicians, bookkeepers, assistants, substitutes, and other professional aides and consultants. Also the Social Security taxes (employer's share only) paid on such salaries. If an employee devotes only part of her services to your professional establishment, deduct a proportionate part of the total salary paid her.

Supplies, Medical Dressings, vaccines, drugs, etc. used in your practice during the year. (See Equipment.)

Supplies, Office If used in your practice. Among the deductible items are billheads, cards, envelopes, ink, labels, letterheads, postage stamps, and printed forms.

Taxes If incurred in the production or collection of income. Under these conditions only, you may deduct the portion you, as an employer, contribute to the Social Security system and to a state unemployment fund; local, city, or county taxes imposed upon a profession or upon personal property used in a profession; real estate taxes on a pro-

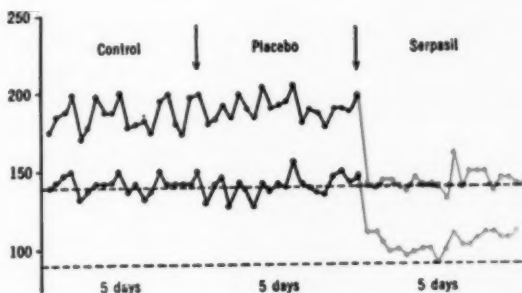
fessional office building (or an allocated portion of real estate taxes on a home-office); taxes on admissions; bond transfer stamps; taxes on cable messages; customs and import duties; deed stamps; taxes on dues, on initiation fees, on property transportation, on radio messages, on safe deposit boxes; stock transfer stamps; taxes on telephone and telegraph messages, on local telephone service, on transportation of persons, on equipment services.

Telephone and Telegraph Such costs when incurred professionally (including a fair share of the expense of your home phone, if so used).

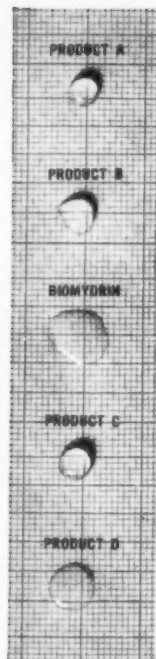
Travel Expenses of going to conventions connected with your practice, or to tax-deductible refresher courses; including baggage transfers, lodgings, meals, railroad fares, plane fares, boat fares, bus fares, telegrams, tips.

Uniforms Purchase price and laundering costs, assuming the uniforms are required by custom or for reasons of cleanliness. Such uniforms must not be suitable for ordinary wear. END

first thought for high b.p.*



* Chart shows actual response to Serpasil in a patient with benign essential hypertension (data on request). Consider Serpasil® (reserpine CIBA) (1) alone to lower blood pressure gradually and safely in most cases of mild to moderate hypertension; (2) as a primer in severe hypertension before more potent drugs are introduced; (3) as a background agent in all grades of hypertension to permit lower dosage and thus minimize side effects of other antihypertensives. **C I B A**



▲
"Spreading action" test of Biomydrin and four other nasal preparations. Drops of equal size were placed on graph paper and immediately photographed. Note: Biomydrin spreads and penetrates quickly, the other drops, even those with wetting agents, show little change.

Ten minutes later, Biomydrin shows an absorption area more than twice the size of some of the others. ▶



Biomydrin's mucolytic action is the difference!

And the difference means better, faster therapeutic action! Biomydrin Nasal Spray makes breathing easier . . . promotes nasal drainage . . . stops sneezing and itching. Biomydrin's unique mucolytic ingredient, Thonzonium bromide, lets all the other active agents get through to the affected mucosa. Patients get the full benefit of *antibacterial* neomycin and gramicidin, *antibistaminic* thonzylamine HCl, and *decongestant* phenylephrine HCl. Safe even for infants.

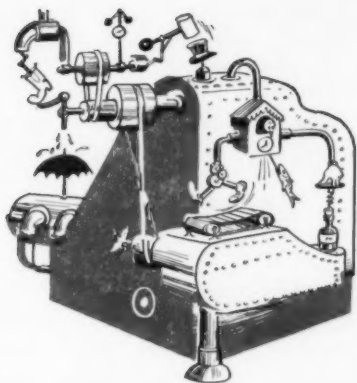
Nepera Laboratories, Morris Plains, N.J.

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NASAL SPRAY

for coryza and allergic or
infectious sinusitis and rhinitis





Doctors Invent The Damndest Things!

Recent patents range from an operable ear to a chair that holds child patients still, from an artificial uterus to a belt that reduces hunger

By Stacy V. Jones

Once upon a time, a French physician named René Laënnec attached a hard rubber ball to the end of a slender, hollow tube—and the now-indispensable stethoscope was born.

Has the age of such doctor-made miracles gone by? Not at all. Despite the demands of modern-day medical practice, the mother of invention still labors and today's doctor continues to deliver. His brain-children are to be found in every corner of the medical world, from the

DOCTORS INVENT THE DAMNDEST THINGS!

classroom to the examining room to the operating room.

For some examples, let's conduct a casual roll-call of a few M.D.-inventors who have patented their ideas in recent months or years.

Patented Ear

To begin with, consider the contribution to the classroom made by Dr. Irvin Hantman, associate professor of otolaryngology at Georgetown. His newly patented teaching device looks and feels just like a human ear. In it the student with otoscope or head mirror can find all the familiar landmarks of the ear drumhead, including the long process of the malleus.

Easy to Incise

This model ear is set in the side of a camera-like box containing a roll of sheep's membrane, instead of film, to simulate the ear drum. Students can make incisions or draw off fluid (from a concealed capsule) exactly as if they were operating on the original. After each operation, a turn of a handle brings a fresh segment of membrane into place so the next operator can start from scratch.

In a similar effort to make teaching more tangible, Dr. H. Richard Bath of Wilmington, Ohio, has perfected a three-dimensional model of the nervous system for use in anatomy and physiology courses. His model consists of plywood cross-sections of the cord brain stem and brain at various levels. Mounted on a supporting frame, these sections have holes drilled in them; the holes accommodate bell wires that complete the tracts.

It Lights Up, Too!

Small three-volt light bulbs represents the cell bodies. The cranial nerves are shown, too. And so is the autonomic nervous system.

Revelation of the human interior has also kept pace with these electronic times on the practicing level of medicine. Dr. Edward Emanuel Sheldon, who heads his own research institute in New York City, holds several patents on an apparatus that takes a TV camera on tour of the alimentary canal. The gadget is a radical departure from old-fashioned endoscopes. It consists of a flexible spiral with a rigid handle and a semi-flexible

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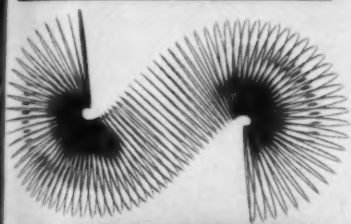
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2 caps t.i.d. (dicyclomine hydrochloride)

quick stop to g.i. spasm...



**no atropine or
belladonna-like
side effects...^{1,2}
safe—even in
the presence of
glaucoma³⁻⁵**

References:

1. McHardy, G. and Browne, D. C.: South. M. J. 45:1139, 1952.
2. Hock, C. W.: J.M.A. Ga. 40:22, 1951.
3. Hufford, A. R.: Am. J. Dig. Dis. 19:257, 1952.
4. Brown, Jr., D. W. and Guilbert, G. D.: Am. J. Ophthal. 36:1735, 1953.
5. Choist, M., Goodstein, S., Berens, C. and Cinotti, A.: Scientific Exhibit, A.M.A., June, 1957.

Capsules, Syrup (plain and with phenobarbital), Tablets with Phenobarbital, and Injection

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DOCTORS INVENT THE DAMNDEST THINGS!

conical tip. A windowed section located near the tip contains the miniature television tube and a light.


Camera Sees All

For the first time, Dr. Sheldon claims, the internal organs can be visually explored no matter what their size or shape. Scenes of the digestive, pulmonary, and other tracts can be reproduced in color or black and white. What's more, any number of doctors can observe them simultaneously. And the photographic records made by this inner eye

are still another advantage that's hard to beat.

Looking into the inside of things presented a different kind of problem to a well-known family practitioner in Washington, D.C. Dr. I. Phillips Frohman believes he has found a humane way to pacify those children who wriggle during chest X-rays, no matter how tightly they're strapped. With his technician, Nicholas V. Festa, Dr. Frohman rigged up a seat with a pair of posts to support both the cassette and the young patient.

MORE▶



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FLEXILON*

combines FLEXIN® Zoxazolamine, clinically established skeletal muscle relaxant,^{1,2} and
FLEXOL® Acetaminophen, a superior analgesic for painful musculoskeletal disorders.³



FLEXILON provides well-tolerated and effective relief of painful muscle spasm associated with back syndrome, strains, sprains, lumbago, and many common rheumatic conditions.

Indications: Tablets, enteric coated, orange, bottles of 100. Each tablet contains: Flexin Zoxazolamine, 125 mg.; and Flexol Acetaminophen 325 mg.

References: (1) Smith, R. T.; Eron, R. M.; Fink, J. R. and Hermann, E. W.: J.A.M.A. 169:765 (June 5) 1966. (2) Sattal, R.: Ann. Pract. & Surg. 12:448 (March) 1961. (3) Rattner, R. G. and Greenman, A. J.: Fed. Proc. 24:16 (March) 1965.

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McNeil Laboratories, Inc. - Philadelphia 19, PA.

sleep
got

DOCTORS INVENT THE DAMNDEST THINGS!

The youngster is told to rest his chin on top of the cassette. Then he's presented with the following challenge: "You've got to hold this thing together, now." Believe it or not, most small fry—an arm around either post, hands clasped across the back of the film holder—will sit there as immobile as a politician in front of a photographer until they're told to relax.

Throw-Away Gown

A solution to another examination-room difficulty comes from a Denver obstetrician, Gunnar Jelstrup. He has patented a disposable wrapper made of a single sheet of soft paper, with an opening for the patient's head. A plastic strap serves as a belt. Perforations divide the robe into panels, and any panel can be removed as the area of examination dictates. (Alive to the whims of individuals, Dr. Jelstrup plans a dispensing package containing garments of various colors as well as sizes.)

The Surgeon's Shoe

The mere act of *walking* into an operating or delivery room can be a serious matter. You know there's always the danger

of explosion of anesthetic gases from static-electricity sparks—which is why you must wear conductive shoes. You can, of course, buy specially made shoes. But why should you? asks Dr. Otto I. Bloom of New York. He has patented a method of encasing any pair of shoes in thin sheets of conductive material. You take any pair you own, replace the soles and heels with conductive rubber, then join them to an inner lining of conductive leather.

None of the above inventions has quite the life-and-death seriousness of one developed by Dr. Emanuel M. Greenberg, a New York gynecological surgeon and obstetrician. His idea was sparked by concern over the mortality rate incident to premature births. Why not, he asked himself, contrive an artificial uterus for premies?

It Works!

So he built a concealed container surrounded by a water jacket (to keep the "uterus" at body temperature). He divided it into separate compartments for the fetus and placenta, with the umbilical cord between. And it apparently works: Experi-

CLINICAL COLLOQUY

My patients complain that the effect of the pain tablet I prescribe often wears off in less than 3 hours.

Why not try the new analgesic that gives faster, longer-lasting pain relief?

You mean something that doesn't require repeat dosage so often?

Yes—it's called Percodan.[®] It not only works in 5 to 15 minutes but one tablet sustains its pain-relieving effect for 6 hours or longer!

How about side effects?

*No problem. For example, the incidence of constipation is rare with Percodan.**

Sounds worth trying—what's the average adult dose?

One tablet every 6 hours. That's all.

Where can I get literature on Percodan?

Just ask your Endo detailman or write to:



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132 MEDICAL ECONOMICS · FEBRUARY 3, 1958

DOCTORS' INVENTIONS

ments with the embryos of white rats have already proved successful.

For Humans Too?

His patent obtained, Dr. Greenberg now plans to experiment with higher animals, and eventually with a human fetus. A possible boon for habitual aborters, his device may also relieve severe cases of Rh incompatibility. The Rh embryo could be taken from the mother and given a new chance at life in this man-made womb.

Food-Substitute

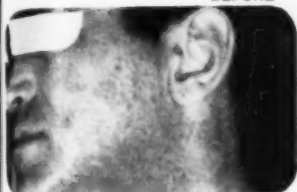
Who knows? One of those struggling babies might live to profit from the inventive efforts of another physician, William S. Kroger of Evanston, Ill. It would take quite a struggle, for Dr. Kroger's device is designed for the overweight patient who can't stop eating. A rounded, pliable lump of plastic that presses against the upper stomach just below the breastbone, it literally fools the stomach into thinking it's full.

Male patients can wear Dr. Kroger's gadget in a specially designed belt. Women can wear it in a special pocket in their girdles. The doctor is convinced through experience that a com-

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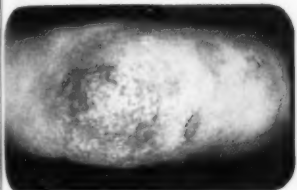


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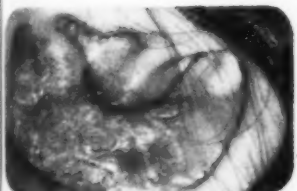
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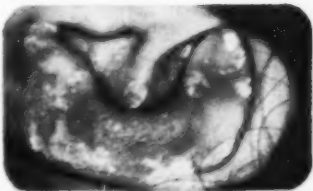
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AND MANY MORE



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Vioform[®]-Hydrocortisone Cream



soap-and-
water
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now also
available as a **Lotion**

Also newly available: VIOFORM LOTION, for patients in whom hydrocortisone is not indicated. For supply of Vioform-Hydrocortisone and Vioform Lotions, write P.O. Box 277, CIBA, Summit, N. J. Request must be made on physician's letterhead or $\frac{1}{2}$ blank.

Supplied: VIOFORM-HYDROCORTISONE Cream, containing iodochlorhydroxyquin 3% and hydrocortisone 1% in a water-washable base; tubes of 5 and 20 Gm. Lotion, plastic squeeze bottles of 15 ml. VIOFORM Lotion, 3%; plastic squeeze bottles of 80 ml.

VIOFORM[®] (iodochlorhydroxyquin CIBA)

C I B A SUMMIT, N. J.

DOCTORS INVENT THE DAMNDEST THINGS!

bination of psychotherapy and his belt-tightener will give far better results than psychotherapy alone, far better than the use of medicinal reducing agents alone.

Not all doctor-inventors confine their talents to dreaming up aids for the medical profession. For instance:

Dr. Herbert H. Kersten of Fort Dodge, Iowa, has invented a refrigerated seat and back-rest for perspiring motorists.

Dr. James E. Roberts of Washington, D.C., has turned his lawn sprinkler into a grass-seeder by adding a special nozzle and a cap into which an inverted Mason jar is fitted.

And, finally, Dr. Harold D.

Lynch of Evansville, Ind., has patented a device for letting in the family pooch without letting in the weather. It consists of overlapping sheets of rubber through which Fido can be trained to writhe and wiggle. How to keep out the neighbors' mutts? Fasten the two rubber sheets high and stop the tall ones; low, and bar the small. If a neighbor has a dog exactly the size of Fido—well, maybe you'd better communicate with Dr. Lynch.

All in all, then, modern medical men seem as inventive a lot as their forebears. How about you? Got a good idea? Better patent it before some imaginative colleague does. END

Playing It Safe

One night after the home delivery of a woman's fourth child, I asked where her husband was. The woman told me she was unmarried, that the father of all her children was a man who lived on the second floor of the house.

I decided I ought to tell this man about his latest offspring. I went upstairs, and he was delighted with my news. Then I asked him frankly why he'd never wed the mother.

"Well, Doc," he said, "when they rejected me for the Army ten years ago, the doctor told me my heart was so bad I ought never to get married. So I never have."

—J. A. M. CEHA, M.D.

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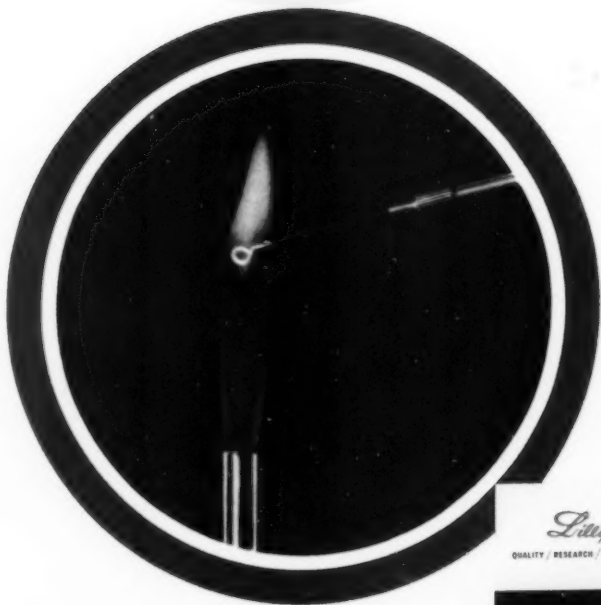
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'Ilotycin' provides, in addition to rapid clinical response, the important advantages only a bactericidal antibiotic can give you.

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Doctors Seek Greater Control Over Blue Shield Plans

By Hugh C. Sherwood Would you and your local colleagues like to have more control over Blue Shield policies? If you had such control, would you insist on greater supervision of the care rendered under your plan?

A large majority of the nation's doctors would vote for more control and more supervision, judging by a recently completed sampling of doctors' opinions in one area.

The Michigan State Medical Society sounded out some 2,500 of the state's 6,300 physicians on almost every aspect of their Blue Shield plan. Not surprisingly, the study indicates that most medical men approve of the health

THIS ARTICLE analyzes some of the findings in a recent Michigan study of doctors' attitudes toward Blue Shield. It's the last of three on the subject. For the first two—"What Physicians Want From Blue Shield" and "What Doctors Want Blue Shield to Pay For"—see MEDICAL ECONOMICS, Jan. 6 and Jan. 20, 1958.



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plan. But it also reveals that they'd like to see some drastic changes.

Among those changes are several pertaining to control and supervision. The tables that follow summarize the doctors' opinions on such matters; and the accompanying text comments on the opinions. For the sake of simplicity, the wording of the questions has been condensed. And all percentages have been rounded off.

Are Local Doctors Given Sufficient Voice in Determining Blue Shield Policies?

No64% Yes36%

It's no secret that many doctors who participate in state-wide Blue Shield plans have long felt that the plans are not truly "theirs." About half the surveyed doctors who feel that way say they'd like to see some control vested in county medical societies. Nearly one in three thinks local specialty societies should have a bigger voice in running the plan.

But if the dissatisfied doctors are to get their wish, they'll probably have to do more than express an opinion. They'll have to exert pressure. While some Blue Shield leaders would like to give local physicians more control—and thus a more proprietary attitude toward the plan—they face administrative problems. One key problem: How many local representatives can be added to a board of directors before it becomes unwieldy?

Should Laymen Be on Blue Shield's Board of Directors?

Yes60% No40%

Although they're often only a small minority, laymen

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do sit on the boards of almost all the nation's Blue Shield plans. Apparently, most doctors like it that way. And in answering an allied question, the Michigan men make it clear they also approve of their plan's policy of having both management and labor represented among the laymen on the board.

Should There Be Supervision of the Care That Is Rendered Under Health Insurance Plans?

Yes79%

No21%

By a three-to-one margin, the doctors also indicate they'd like policing committees set up on the community level—preferably as units of county medical societies. As a result of the survey, they'll probably get something pretty close to their wish: an over-all state-wide committee, plus a number of district committees, to keep watch on Blue Shield care. The committees are scheduled to be made up solely of physicians.

Although a few other Blue Shield plans have set up watchdog committees, this appears to be the first time doctors have agreed to handle the job themselves. Since the idea appeals to most Blue Shield officials, the Michigan men may set a precedent for other states.

Who's chiefly responsible for the abuses such proposed committees would be out to stop? Here's what the surveyed doctors who vote for supervision think:

Over Whom Should Supervision Be Exercised?

Over doctors	38%
Over hospitals	32
Over patients	30

But most of the respondents believe they themselves

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have nothing to hide. For proof, some 83 per cent of all the surveyed practitioners say they'd have no objection to reporting the total fee they charge each Blue Shield patient.

If Blue Shield needs more supervision and medical control, Blue Cross needs it even more, the Michigan M.D.s indicated in reply to two other questions. The first:

Do Local Physicians Have a Big Enough Voice In Determining Blue Cross Policies?

No71%

Yes29%

Although most Blue Cross plans have some doctors on their boards of directors, the medical profession has never exercised any great amount of control over Blue Cross policies. Apparently, most doctors would welcome a change.

But would they fight for it? One key observer doubts it. "The medical profession has long had a tendency to regard Blue Cross as the property of the American Hospital Association," he says. "As long as that sentiment prevails, I imagine Blue Cross will remain the property of the A.H.A."

Should There Be Supervision of the Use Made of Blue Cross Benefits?

Yes85%

No15%

One man who's close to Blue Shield says he's detected a new attitude toward Blue Cross in recent years: "There's less tendency to cry 'Abuse!' these days. Doctors are beginning to realize that their colleagues and the

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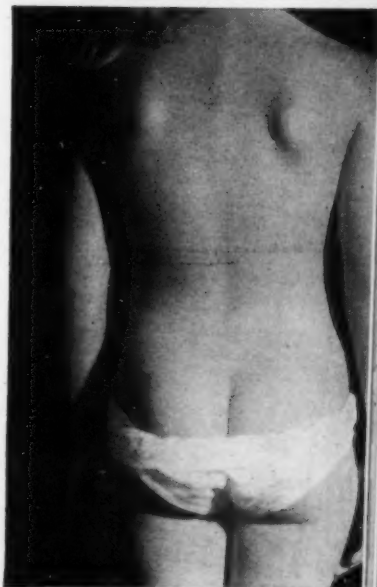
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hospitals aren't abusing benefits; they're just giving more and better treatment, and they're doing it earlier in the course of the disease." But if the Michigan survey is a criterion, a big majority of physicians need further convincing.

What would supervision of Blue Cross mean? It might eliminate alleged abuses. It might also end a number of hospital bed shortages. And it might result in lower premiums for subscribers.

But these are only possibilities. From the entire study, in fact, one gets the over-all impression that doctors in general have a healthy openmindedness toward the Blue plans. They'd like to see them provide even more effective service than they now do. And if service can be improved through greater supervision of doctors, the doctors themselves seem eager to cooperate. END

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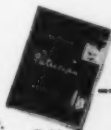
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TAKE A LESSON FROM THE

15. The Case of the

By Xavier F. Warren

EDITOR'S NOTE: *Here's the fifteenth in a series of true incidents selected from the confidential file of a malpractice insurance company's claims adjuster. Although names and identifying details have been changed, the stories accurately portray recent happenings.*

Dr. Henry Follard's thoughtfulness cost us \$4,000 last year. Lord knows, he meant well in his effort to spare a poor family some needless expense. But he laid himself wide open to a charge of saving money instead of saving a human life.

The Zabrowskis didn't have a phone at their house. To call Dr. Follard, they had to go down to the little candy store on the corner. They didn't have a car, either. And it's not easy to take a sick baby through two changes of bus in midwinter. But they hated to ask Dr. Follard to come to the house. They knew how busy he was and how little they could afford.

So Mrs. Zabrowski telephoned the doctor and explained about the baby's cold. And he told her what to do. He also said she should phone him again if the baby hadn't improved in a couple of days.

FROM THESE MALPRACTICE MISHAPS!

e of the Money Saved

A week passed with no call from the Zabrowski home. Dr. Follard figured all was well. Anyhow, he had a hundred other kids with anxious parents to worry about that winter.

Then one evening, just as he was sitting down to dinner, Mrs. Zabrowski called. She wasn't a well-educated woman, but her description of the baby's illness was vivid and clear. She described a moribund child.

Dr. Follard had his wife put dinner in the oven while he drove to the other side of the tracks. There he found a baby dying of bronchopneumonia.

Something like this went through Dr. Follard's mind, as he explained it to me later: "This poor infant is going to die in a few hours. Nothing can save him. And here's the Zabrowski family, with two other children, putting up a brave struggle to live on \$43 a week. They have no savings and no hospital insurance—yet they aren't eligible for free ward care. If I put the baby in the hospital for a few useless hours, it will cost Mr. Zabrowski more than he ought to have to pay. Isn't it far better to let the baby pass out peacefully here instead of ambulancing

THE CASE OF THE MONEY SAVED

him through the icy streets to an expensive death in a hospital bed?"

Without putting any of these thoughts into words, Dr. Follard gave an antibiotic injection and softly retreated. That was at 7 P.M. The child died six hours later.

Three days after that, the Zabrowski family filed suit. Their allegation: that a hospital with all its oxygen tanks, wonder drugs, and twenty-four-hour nursing service might have saved the baby. They said Dr. Follard had been guilty of malpractice in keeping the infant home.

The county medical society couldn't see that the Zabrowskis had any sort of case. Dr. Follard had driven down to the Zabrowski house the minute he knew he was needed. There'd been no medical mistake. And he hadn't charged a cent.

Dr. Follard and his colleagues were indignant wher-



we advised settlement, if we could get it for \$5,000 or less. But then I asked him to imagine the spot he'd be in when the plaintiffs' attorney asked in court: "Why didn't you send the baby to the hospital?"

Could the doctor answer that the ride might have made matters worse? No, he couldn't. He'd already have testified that matters could *not* have been worse.

Well, could he answer: "I did it to save the family some money"? Think how that would sound to a jury! He had weighed a child's life against dollars and cents!

Dr. Follard authorized us to settle, and we did—for \$4,000.

Sure, it's good for medical men to be economical in their handling of most cases. But not in life-or-death cases—not if saving money could possibly be thought to conflict with saving lives.

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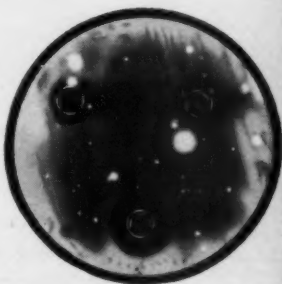
80% of 236 cases of acute and chronic prostatitis
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	No. patients	Cured	Improved	Unimproved
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Total	236	66	128	42

80% (142) of 170 cases of postprostatectomy infection responded favorably
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Surg. M. 51:280, 1954.

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By Chester Porterfield Treat the poor man at cut rates; charge the rich a stiff fee. That's a philosophy a lot of my doctor-clients will fight for. They don't like it when I call it a "soak-the-rich" plan. And they like it less when I point out that to many a layman it sounds like a proposal to charge all the traffic will bear.

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THE AUTHOR is vice president of Medical Management Control, San Francisco.

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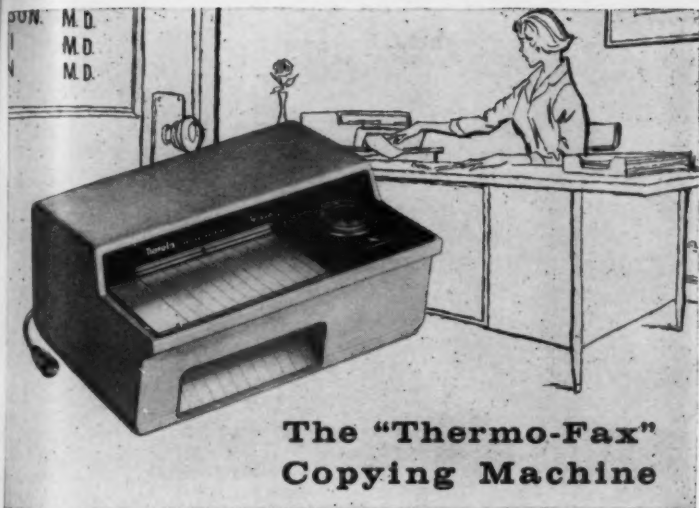


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MEDICAL ROBIN HOOD?

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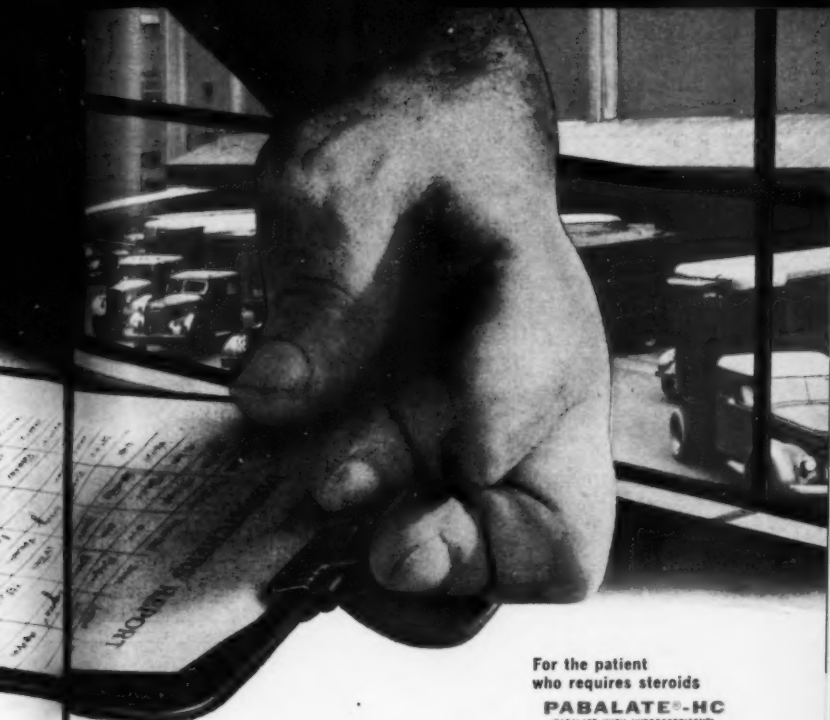


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ARE YOU A MEDICAL ROBIN HOOD?

other extraordinary demands on the physician.

"The doctor assumes greater responsibility with a rich patient."

A good many conscientious medical men would dispute this. Sure, they'd admit that bad publicity following a bungled case would be more serious with a prominent patient than with an obscure one. But they'd maintain that no doctor has an ethical right to permit such considerations to affect either his treatment or his fees. The doctor's responsibility, they'd say, never

varies according to the economic status of the patient.

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Of course medical care must not be commercial. But we management men have learned that the all-important clinical procedures in the doctor's office are given their best chance when the business aspects of his practice are handled in a businesslike manner. Fee-setting is one of those business aspects. If done systematically, it leaves the doctor free to concentrate on his medical tasks.

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Composition: Each tablet contains 400 mg. meprobamate and 1 mg. benactyzine HCl

Average Adult Dose:
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1. Proctor, R. C.: *Dis. Nerv. Sys.* 18:223, 1957.

2. Fourn, C. D., and Gragg, L., Jr.: *Dis. Nerv. Sys.* 18:29, 1957.

3. Conis, E. A., and Gray, R. W.: *Dis. Nerv. Sys.* 18:191, 1957.



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"If your patient can't afford your usual fee, by all means quote him a reduced fee. Find out where he stands in advance, then make an allowance, discount, or time-payment arrangement tailored to the case."

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your fees down when necessary is very different from *raising* them arbitrarily for the patient who's well heeled.

"I want to charge what I want when I want to, and nobody is going to tell me otherwise."

Well, if that's how you feel—and I know that some doctors do—I have no answer for you. I'm a medical management consultant, nothing else. All I can say is that in my observation it's not good business or good medicine to set fees that way. It's every bit as dated as—well, as Robin Hood.

END

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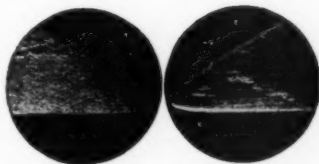
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Photomicrograph of scalpel immersed in ordinary germicide 6 months shows pitting (left), and in C. R. I. germicide 6 months, none.

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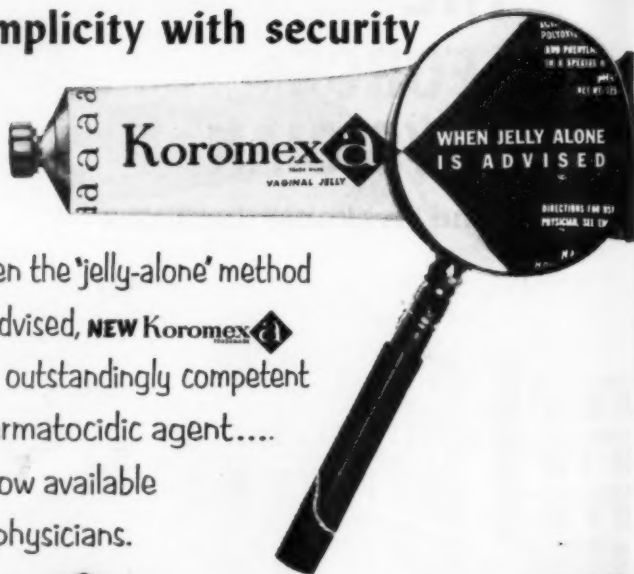
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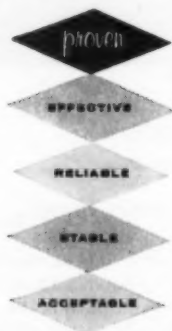
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3 Ways to Get Faster, Better Histories

*You can speed up your interviews by looking for
turning points or providing your own—
and by summarizing as you go along*

By John E. Eichenlaub, M.D. Wouldn't it be wonderful if you could lead each patient easily from fact to fact until you had all pertinent information you needed? If you could move the interview along, yet still leave each patient feeling that he hadn't been hurried? That's where these three interviewing techniques may help:

1. Use turning points provided by the patient himself.

Jim Armstrong had told me a good deal about his stomach pains. Just when it seemed time to change the subject, he happened to remark: "It doesn't seem to matter what I eat. Whenever I'm under pressure, my stomach gets upset."

"Then your trouble is connected with pressure?" I asked. "Are you under some kind of pressure now?"

"Yes, I guess I am."

Jim went on to tell me about his business worries. He

3 WAYS TO FASTER, BETTER HISTORIES

hardly noticed the conversation had switched to psychic factors in disease—a subject I've always found hard to bring up without hurting rapport. The transition went smoothly because it rose out of a turning point he himself had created.

Experienced interviewers are always on the lookout for such a turning point. Once it's presented, the transition doesn't have to be too logical. Colleagues have told me how a patient's remark about the rush of getting children off to school was used to lead into the patient's relationship


with his own parents. Or how a comment that "I sleep soundly" became the springboard for discussing sex. The important thing is to take advantage of whatever jumping-off place the patient offers.

2. *If the patient doesn't provide you with enough turning points, inject your own into the conversation.*


What remarks can you use for this purpose? Here are a few that experienced interviewers use:

"That brings up the subject of such-and-such . . ." (The connection may be remote. I don't

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3 WAYS TO FASTER, BETTER HISTORIES

believe I've ever had a patient ask about it.)

"Let's get a little more background . . ."

"Now let's get on to such-and-such . . ."

Sometimes it takes more than words to change the subject. Some doctors shuffle pages of the patient's record; others sit back and light a cigarette. Thus they deliberately create a conversational void from which to take a fresh start.

3. *Summarize the patient's story for him as he goes along.*

Most sick people can't help

talking in circles. They don't have the facts marshalled into any semblance of order; they're too worried or frightened to systematize and select. That's why most doctors find the periodic summary so useful. The patient talks awhile, then you might say:

"Now let's see whether I've got this straight. You felt fine until last Tuesday, then this pain started in your left side . . ."

This helps the patient to get through his story. And if at any time he starts back over the ground he's already covered, you can intercept him with this:

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Treatment course: 1 ml. daily for 6–8 days. Eliminates skin-testing, special diets, and long-drawn-out desensitization procedures.

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- urticaria, especially in infants
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1. *Clin. Med.* 2:1009, 1955.
2. *Amer. Pract. & Digest Treat.* 7:1447, 1955.
3. *Clin. Med.* 3:1059, 1956.
4. Unpublished data.

Available: multiple-dose vials containing 5 ml.—one average treatment course.

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3 WAYS TO FASTER, BETTER HISTORIES

"I'd like to get all the details on that, but let's fit them in with what I've got clear already. Now, you had this pain in your left side, sort of knifelike. Anything you can add to that?"

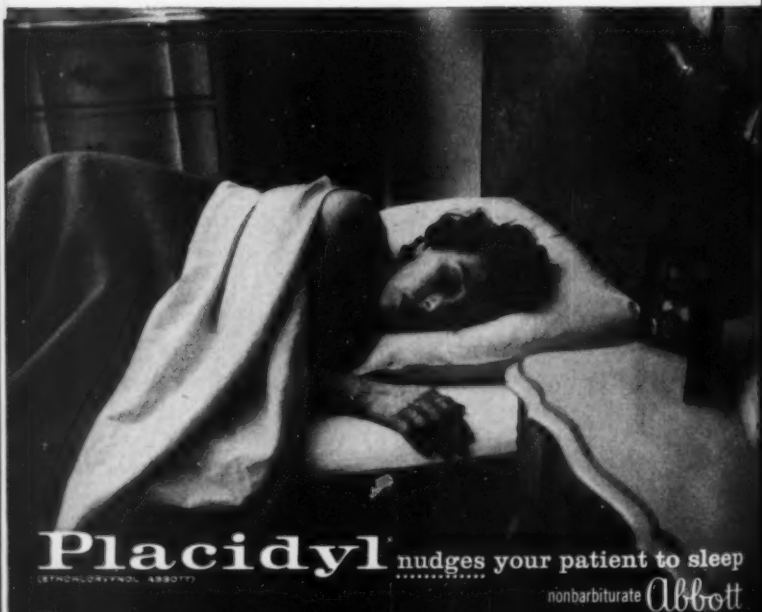
An easy way to summarize in the middle of an interview is to read back key parts of the patient's record. "Now," you say, holding the history card up, "Tuesday P.M.—knifelike pain in left side. Wednesday—vomited once. What about after that?" And the interview moves along.

Men who have mastered these three simple interviewing tech-

niques say that they produce more than just faster, better histories. They also create an impression on the patient that may be equally important.

After all, history-taking isn't a one-way street. *You're* on display in the exploratory interview as much as any patient. *Your* expertness is on trial—and that means expertness in handling people and in handling yourself.

You'll do all right if you use the interviewing ideas described here. They're the signs of an expert. And they impress most patients accordingly. END



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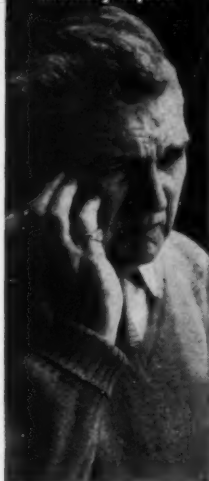
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keep
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fatigue



memory lapses



muscular pain



depression



for middle-age slowdown

Plestran is indicated as an aid in restoration of vigor in middle-aged or elderly patients who complain of chronic fatigue... reduced vitality... low physical reserve... impaired work capacity... depression... muscular aches and pains... or cold intolerance. Such "signs of aging," far from being due to physiologic disturbances, may often result from endocrine imbalance, especially gonadal and thyroid dysfunction.¹⁻⁴ Plestran provides ethinyl estradiol (0.005 mg.); methyltestosterone (2.5 mg.), and Prolloid® (¼ gr.)—hormones which help to correct endocrine imbalance and often halt or reverse involutional and degenerative changes.¹⁻⁴

Plestran restores work capacity and a sense of well-being, usually within 7 to 10 days. It improves nitrogen balance, leads to better muscle tone and vigor, enhances mental alertness, helps to cor-

*Purified thyroid globulin

rect osteoporosis, senile skin and hair texture changes and relieves muscular pain.

The anabolic and tonic effects of the hormones in Plestran appear to be enhanced by combination so that small dosages are very effective. Combination also overcomes some of the disadvantages of therapy with a single sex hormone, such as virilization, feminization or withdrawal bleeding.⁵

Dosage: Usually one tablet daily; occasional patients may require two tablets daily, depending on clinical response.

Supplied in bottles of 100 and 500.

References: 1. McGavack, T. H.: *Geriatrics* 5:151 (May-June) 1950. 2. Masters, W. H.: *Obst. & Gynec.* 8:61 (July) 1956. 3. Kimble, S. T., and Stieglitz, E. J.: *Geriatrics* 7:20 (Jan.-Feb.) 1952. 4. Kountz, W. B., and Chieffi, M.: *Geriatrics* 2:344 (Nov.-Dec.) 1947. 5. Birnberg, C. H., and Kurzrok, R.: *J. Am. Geriatrics Soc.* 3:656 (Sept.) 1955.

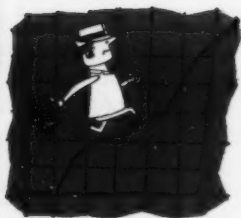
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Low Liability Limits Are Being Raised

How much malpractice insurance should you carry? There have been two main schools of thought among the experts:

1. *Maximum coverage.* Doctors not insured for at least \$100,000 "leave themselves open to financial ruin," according to this view. It predominates in high-risk specialties and in claims-conscious areas like California and New York City. Median malpractice coverage in those areas reached \$100,000 two years ago, a MEDICAL ECONOMICS survey showed.

2. *Minimum coverage.* Plaintiffs' attorneys set their sights according to the amount of insurance the doctor has. Thus "the lowest limits appropriate to your specialty and location" help hold down court awards. This view has prevailed in the Midwestern states and some others. Median malpractice coverage there stood at \$25,000 in 1956, and many M.D.s in the area had \$5,000 or \$10,000 coverage only.

Torn between these conflicting views, most doctors elsewhere chose moderate malpractice limits in the \$25,000-to-\$75,000 range. And now the No. 1 exponent of *minimum* coverage is going along with them:

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But low limits apparently made many policyholders nervous when they read what other doctors were being sued for. Some switched away from Medical Protective. So now the lid's off:

As soon as state insurance commissioners approve, Medical Protective will offer malpractice coverage in the \$25,000-to-\$75,000 range. "It may go as high as \$100,000 in some areas," says T. E. Haberkorn, vice president of the company. "But it won't generally be that high, and it will be very carefully underwritten—not offered promiscuously."

Thus the leading advocate of low limits has come around to moderate limits. There's a lesson there for every doctor who wonders how much malpractice insurance is enough. **END**

*Incidence of suits hasn't increased in recent years; court awards have been held to an average of \$1,757; premiums have remained "almost unchanged since 1929," the company says.

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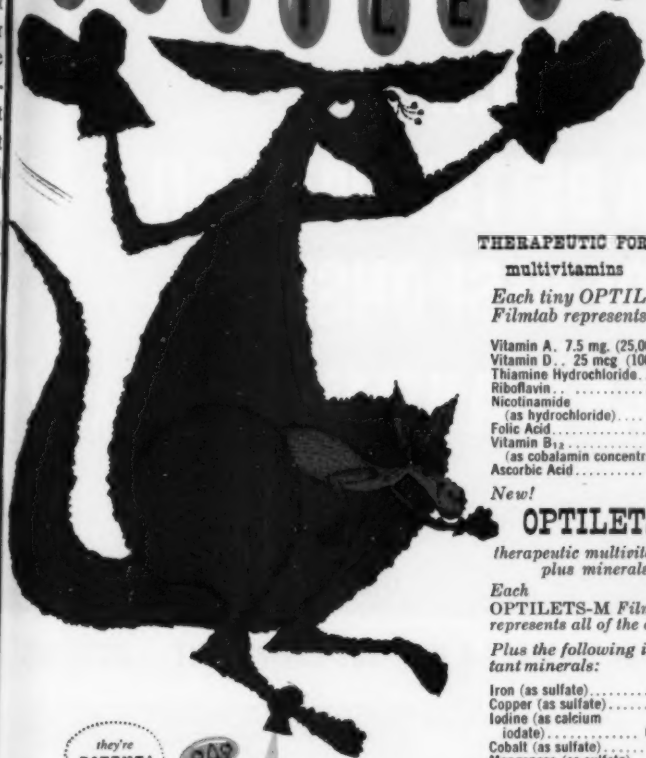
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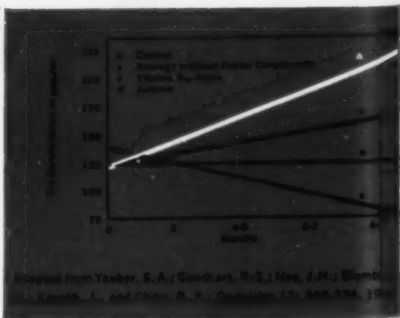
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DOCTORS TALK BACK

[CONTINUED FROM 83] some of the 'heroic souls' who testify most often for plaintiff lawyers. Several of these doctors 'practice' in New York City courts. They earn their living by serving as witnesses several times a week. And they're 'experts' in any or all branches of medicine. Are these the men Mr. Belli would have us emulate?"

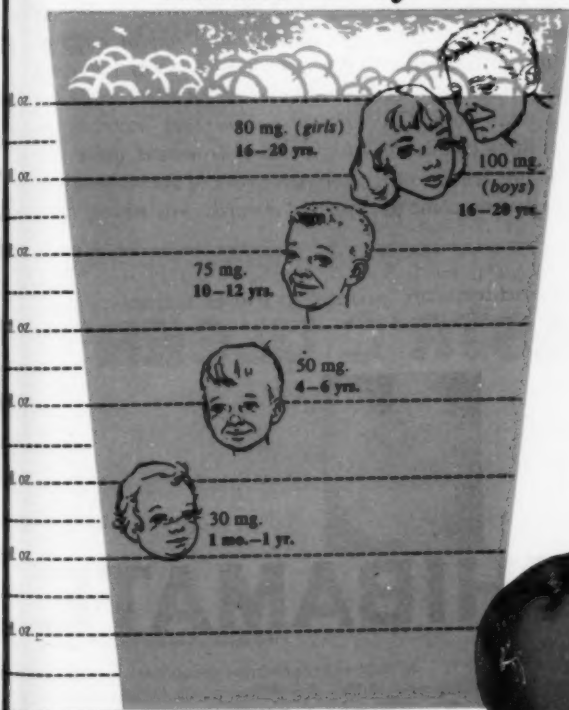
'No Pressures Here'

Says Dr. C. S. Bluemel, chairman of the Medicolegal Committee of the Colorado State Medical Society: "If such pressures as Mr. Belli mentions exist, they haven't reached Colorado. The committee of which I'm chairman investigates all malpractice claims. But it doesn't inquire into the identity of the claimant's prospective witnesses. Nearly two-thirds of the claims are found to be mercenary and unwarranted. And those that have substance are usually settled out of court."

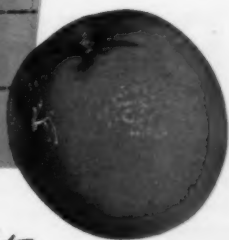
'Shoddy Tactics'

Says Dr. James A. Gannon of Washington, D.C.: "Over a forty-year period I've frequently testified in court as an expert—often for the defendant, sometimes for the plaintiff. Not once have I felt 'pressure' from a med-

for developmental years
orange juice
 capably supplies
 recommended daily
 intakes* of vitamin C



*Nat. Res. Council,
 Pub. 302, 1953.



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 ORANGES • GRAPEFRUIT • TANGERINES

DOCTORS TALK BACK

ical society or an insurance company. The medical witness who tells the truth doesn't fear reprisals. But he does object—and with good cause—to some of the shoddy questioning tactics which many lawyers use."

Says Dr. Paul De R. Kolisch of Phillipsburg, N.J.: "Mr. Belli knows very well that most doctors carry malpractice insurance. And we know it's most unusual for an insurance company to go to court with a weak case. (In fact, many of us think insurance companies settle too readily out of court.) Cases that do come to

trial, then, are often those of least merit. So the reluctance of doctors to testify for the plaintiff in such cases is completely understandable."

Those Malpractice Premiums

Melvin Belli charged that insurance companies seize on even nominal awards to jack up their premium rates "out of all proportion to the amount [they're] out of pocket." And he scoffed at the argument that increasingly higher awards would drive the companies out of the malpractice field: "Awards will never keep

when anxiety and tension "erupts" in the G. I. tract...

IN GASTRIC ULCER



PATHIBAMATE*

Meprobamate with PATHILON® Lederle

Combines Meprobamate (400 mg.) the most widely prescribed tranquilizer . . . helps control the "emotional overlay" of gastric ulcer—without fear of barbiturate loginess, hangover or habituation . . . with PATHILON (25 mg.) the anticholinergic noted for its extremely low toxicity and high effectiveness in the treatment of many G.I. disorders.

Dosage: 1 tablet t.i.d. at mealtime. 2 tablets at bedtime.

Supplied: Bottles of 100, 1,000.



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It's the good-tasting

protein-vitamin-mineral supplement

for patients requiring diet therapy,

such as **GERIATRICS, ULCERS AND TUBE****FEEDINGS.** Meritene is more nutritive

than an equal amount of eggnog, yet

is lower in fat and lower in cholesterol.

It costs less and tastes good, too.

THE DIETENE COMPANY

The house of good-tasting protein products

DOCTORS TALK BACK

pace with the companies' ever-mounting profits . . ."

Says New York City's Dr. Herbert Berger: "Mr. Belli's criticism of malpractice premium rates is at complete variance with independent actuarial studies. An actuary employed by our medical society tells us that our plan simply couldn't be carried at a lower premium. And two insurance companies have refused to renew the New York State contract because they lost heavily on it."

'Why Do They Give Up?'

Says Dr. Donald T. Hall, chairman of the Medical Defense Committee of the Washington State Medical Association: "If Mr. Belli's right, why do most insurance companies that start soliciting malpractice business give it up after several years' trial? The truth is, they find it unprofitable even at existing rates. Those that stay with it usually do so because of ancillary policies doctors buy from them."

Risky Procedures

Melvin Belli derided the idea that zooming malpractice awards might cause doctors to stop taking necessary risks in future treatment of patients . . .

Says Dr. John S. DeTar, past

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(Brand of phenylazo-diamino-pyridine HCl)

**fills the gap between
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Pyridium (the urinary tract anesthetic) relieves discomfort and painful symptoms even before the effects of specific therapy can begin. In 20-25 minutes, Pyridium alleviates pain, urgency, frequency and burning.

When there is no infection, Pyridium eases the discomfort of chronic, non-specific urinary tract disorders, gives prompt in-the-office relief. It affords a fast-working analgesic for instrumentation, or may be used to keep patients comfortable until surgery.

When infection is present, use Pyridium as always with any treatment you choose, or to supplement combination therapy whenever additional analgesia is required. While waiting for diagnostic test results or for fever to come down, you can provide fast relief from pain and discomfort with Pyridium.

Diagnosis or treatment may take time—but pain relief can be immediate. Use Pyridium for *every* case with urinary tract pain, for relief in minutes.

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PROVIDES SOFT STOOLS GENTLY STIMULATED TO EVACUATION

DOXINATE® with DANTHRON (Doxan)

— the original dioctyl sodium sulfosuccinate fecal softener combined with danthron, the non-irritating, non-habit forming laxative —

Comprehensive control of constipation with Doxan . . .

- ★ Prevents fecal dehydration and gently stimulates the lower colon in functional constipation
- ★ Synergistically provides, with a subclinical dosage, peristaltic action on a soft, "normal" intestinal content rather than on the hardened mass typical of constipation
- ★ Results in soft stools gently stimulated to evacuation . . . and restores normal bowel habits

Doxinate with Danthron (Doxan) is supplied as brown, capsule-shaped tablets containing 60 mg. dioctyl sodium sulfosuccinate and 50 mg. 1, 8-dihydroxyanthraquinone.

Usual adult dose: One or two capsule tablets at bedtime. Bottles of 30 and 100.

When fecal softening alone is indicated—

Doxinate 240 mg.—provides optimal once-a-day dosage for maintenance therapy.

Doxinate is a registered trademark of Lloyd Brothers, Inc.

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DOCTORS TALK BACK

president of the American Academy of General Practice: "In warning doctors to stay in their fields of competence, Mr. Belli's article may have some salutary effect. But this is negated by the article's demonstration of the personal risk doctors take in treating their patients. Many physicians will hesitate to perform life-saving procedures because of the ever-present threats of lawyers like Mr. Belli."

Says Dr. Samuel M. Day of Jacksonville, Fla.: "Drug manufacturers (who've had experience with lawyers, too) list only minimum dosages in their literature. In practice, it's often necessary to prescribe greater dosages for desired effects. But with the growing threat of suits, we'll think twice before doing so. The

same will hold true of necessary but potentially risky procedures. It's the patient who'll suffer."

'Speaks for Itself'

Melvin Belli said: "I often manage to obviate the need for [experts] by invoking the . . . principle of res ipsa loquitur—the thing speaks for itself" . . ."

Says C. Joseph Stetler, director of the A.M.A.'s Law Department: "Numerous vices are inherent in a distortion of the *res ipsa loquitur* doctrine. It's unfair to the jury in professional liability cases, since jury members aren't permitted the medical education and assistance they need in order to form a fair judgment. It's also grossly unfair to the defendant doctor, because it subjects him to a rule of sympathy

One Down

A medical student was told to sigmoidoscope a woman who had functional bowel complaints. After inserting the instrument, he noticed a red annular lesion with a very narrow luminal opening. He called the resident. "A napkin-ring cancer!" said the resident. And he did a biopsy. When the pathologist's report came back, it read: "Benign cervical tissue."

—LEON G. SMITH, M.D.

anxiety is the voice of stress

heart
disease
is a state
of stress

Case-Report Abstract: H.R., male, aged 40

Severe anxiety complicating acute posterior myocardial infarction, with sinus tachycardia and premature ventricular contractions. Prompt improvement followed the use of EQUANIL to calm the patient. The heart rate slowed, the premature contractions subsided, and the patient responded to reassurance. Medication with EQUANIL continues, and the patient has returned to work.¹

"Cardiac patients who show significant manifestations of anxiety should receive a taractic treatment as part of the therapeutic approach. . . ."

1. Waldman, S., and Perner, L.: *Am. Pract. & Digest Treat.* 8:1075 (July) 1957.

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EQUANIL

Meprobamate

PHENERGAN® HCl

Promethazine HCl

SPARINE® HCl

Promazine HCl



A Wyeth normotrophic drug for nearly every patient under stress

Philadelphia 1, Pa.

E

Equanil

Meprobamate

**Relieves tension—
mental and muscular**

DOCTORS TALK BACK

and jury speculation, often with disastrous results. Distortion of *res ipsa loquitur* makes serious inroads on the sound legal principles that give proper protection to the medical profession."




Says Dr. C. B. Gardner of Merkel, Tex.: "There have been many cases in criminal prosecution where innocent persons have been convicted. At some later date, a newspaper reporter or other investigator has proved they weren't guilty. *Res ipsa loquitur*: The defending lawyer was negligent or incompetent. Why shouldn't he be compelled to

compensate the aggrieved (or his survivors) in six-digit figures?"

Obvious Guilt?

Melvin Belli described in detail a number of cases in which he'd been lawyer for the plaintiff. In each of them—whether won or lost—he held that the defendant doctor had obviously been guilty of malpractice . . .

Says Dr. James A. Gannon of Washington, D.C.: "Mr. Belli holds in great contempt the doctor who testified that maggots therapy was not unusual. I was chief of staff of the District of



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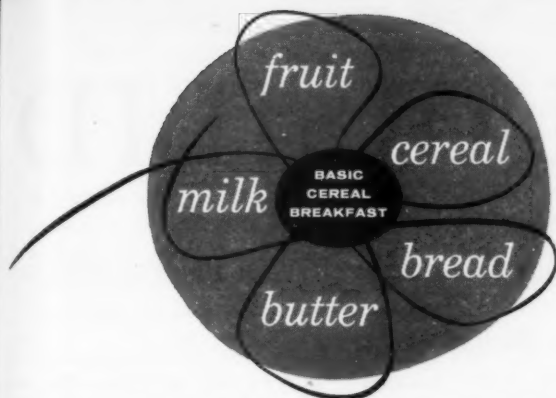
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When a reduction of fat in the diet is indicated in the morning meal, the fat calories can be replaced by those of *low-fat* content yet providing well-balanced nourishment and quick and lasting energy throughout the morning hours.

The Iowa Breakfast Blood Sugar Studies proved that a basic cereal and milk break-

fast providing about 20 gm. mixed plant and animal protein (cereal and milk) provided quick and lasting energy throughout the early and late morning hours. As shown in the table below this morning meal is *low in fat* and provides well-balanced nourishment.

basic cereal low-fat breakfast pattern

Orange juice, fresh, $\frac{1}{2}$ cup,
Cereal, dry weight, 1 oz.,
with whole milk, $\frac{1}{2}$ cup,
and sugar, 1 tsp.,
Bread, white, 2 slices,
with butter, 1 tsp.,
Milk, nonfat (skim), 1 cup,
black coffee

Nutritive value of basic cereal breakfast pattern

CALORIES.....	502	VITAMIN A.....	600 I.U.
PROTEIN.....	20.5 gm.	THIAMINE.....	0.46 mg.
FAT.....	11.6 gm.	RIBOFLAVIN.....	0.80 mg.
CARBOHYDRATE	80.7 gm.	NIACIN.....	3.0 mg.
CALCIUM.....	0.532 gm.	ASCORBIC ACID..	65.5 mg.
IRON.....	2.7 mg.	CHOLESTEROL..	32.9 mg.

Note: To further reduce fat and cholesterol use skim milk on cereal which reduces Fat Total to 7.0 gm. and Cholesterol Total to 16.8 mg. Preserves or honey as spread further reduces Fat and Cholesterol.

Bowes, A. deP., and Church, C. F.: *Food Values of Portions Commonly Used*. 8th ed. Philadelphia: A. deP. Bowes, 1956.
Cereal Institute, Inc.: *The Nutritional Contribution of Breakfast Cereals*. Chicago: Cereal Institute, Inc., 1956.
Hayes, O. B., and Rose, G. K.: *Supplementary Food Composition Table*. J. Am. Dietet. A. 33:26, 1957.
Cereal Institute, Inc.: *A Summary of the Iowa Breakfast Studies*. Chicago: Cereal Institute, Inc., 1957.

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A research and educational endeavor devoted to the betterment of national nutrition

the new psychic energizer

MARSILID

(iproniazid) *Roche*

"a major breakthrough... in mental disease"

Q. What is Marsilid?

- A.** Marsilid ROCHE (iproniazid) is a psychic energizer—the very opposite of a tranquilizer—of unparalleled value in mild and severe depression. Marsilid is an amine oxidase inhibitor which affects the metabolism of serotonin, epinephrine, norepinephrine and other amines.

Q. How does Marsilid act?

- A.** Marsilid restores a feeling of well-being and promotes an increase in appetite, weight and vitality. It restores depleted nervous energy and stimulates appetite and weight gain in chronic debilitating disorders.

Q. How soon is the effect of Marsilid apparent?

- A.** Marsilid is a relatively slow-acting drug; even in mild depression results may not be evident for a week or two. In chronically depressed or regressed psychotics, results may be apparent only after a month or more.

Q. How does Marsilid compare with shock treatment?

- A.** Marsilid usually obviates the need for shock treatment. The drug has repeatedly been effective in patients who had not responded to shock therapy (both insulin and electroshock).

Q. What is the dosage of Marsilid?

- A.** *Like all potent drugs, Marsilid requires individual dosage adjustment.*

*T. R. Robie, paper read at First Marsilid Symposium, New York City, November 29, 1957.

ment for best results. Since Marsilid has a cumulative action, the dosage should be reduced after improvement is evident. *Ambulatory Patients* (mild depression): 50 mg daily—given in divided doses or as a single dose—followed by a gradual reduction to a lower maintenance dose until discontinuation of therapy becomes feasible. *Hospitalized Patients* (depressed and regressed psychotics): 50 mg t.i.d. until improvement is evident (in severe psychoses several months of treatment may be necessary before patients improve). Then reduce to lowest level at which improvement can be maintained. If Marsilid, or Marsilid with dextro-amphetamine, does not produce improvement, the addition of 1 mg of reserpine daily may result in a favorable response.

Q. What precautions should be taken with Marsilid?

- A. While excessive doses of Marsilid may cause side effects, these reactions are usually reversible upon reduction of dosage or cessation of therapy. Vitamin B₆ (pyridoxine hydrochloride) frequently obviates or alleviates side reactions due to Marsilid. Marsilid should be used cautiously, if at all, in overactive, overstimulated or agitated patients because it may cause excessive stimulation; it is primarily recommended for depressed patients. Marsilid is probably contraindicated in patients with impaired liver function or with a history of previous liver disease; therapy should be interrupted promptly if jaundice appears. In patients with impaired kidney function, Marsilid should be used cautiously to prevent accumulation. Marsilid should not be used in epileptic patients.

Q. What is the clinical background of Marsilid?

- A. The therapeutic usefulness of Marsilid has been described in over 50 recent publications. For reprints and information on the clinical use of Marsilid, write to Professional Service Department, Roche Laboratories, Nutley 10, New Jersey.

- Marsilid® Phosphate—brand of iproniazid phosphate (1-isonicotinyl-2-isopropyl hydrazine phosphate)

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subjectively: better tranquillization
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ANTIHYPERTENSIVE ♦ TRANQUILIZER
with fewer and less severe side effects

MODERIL®

BRAND OF RESCINNAMINE

the new, safer alkaloid of rauwolfia

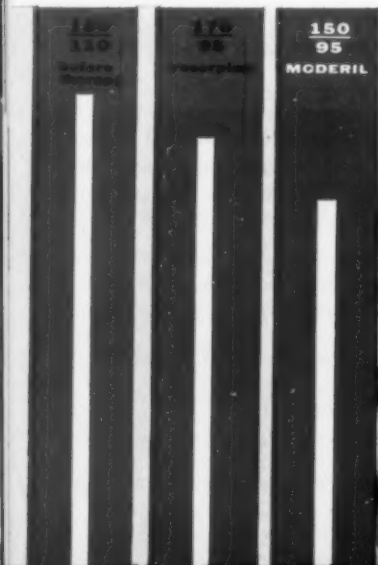
Moderil is better tolerated than other rauwolfia drugs, permits higher doses and improved control of tension and hypertension in patients with acute anxiety states and patients with hypertension; affords pronounced beneficial effects in patients with chronic mental disturbances.¹⁻⁷

Supplied: MODERIL TABLETS, 0.25 mg., oval, scored, yellow colored, bottles of 100 and 500; 0.5 mg., oval, scored, salmon colored, bottles of 100.

References: 1. Winton, S. S.; Personal communication. 2. Smirk, F. H., and McQueen, E. G.; *Lancet* 2:119 (July 16) 1955. 3. Hershberger, R. L.; Dennis, E. W., and Moyer, J. H.; *Am. J. M. Sc.* 231:542 (May) 1956. 4. Moyer, J. H.; Kinard, S. A.; Hershberger, R., and Dennis, E. W.; *South. M. J.* 50:499 (April) 1957. 5. Hollister, L. E.; Stannard, A. N., and Drake, C. F.; *Dis. Nerv. System* 17:280 (Sept.) 1956. 6. Winton, S. S.; *Internat. Rec. Med.*, in press. 7. Malamud, W.; Barton, W. E.; Fleming, A. M.; Middleton, P. McK.; Friedman, T. T., and Schleifer, M. J.; *Am. J. Psychiat.* 114:193 (Sept.) 1957.

Pfizer Laboratories, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.

Pfizer



Y. S.,² a 65-year-old woman with moderate essential hypertension, with blood pressure of 180/110 before therapy. With reserpine, blood pressure averaged 170/95. Subsequent therapy with Moderil gave average readings of 150/95 to 140/90. Moderil reported as "much better . . . no side effects. . . . Excellent results in every respect."



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DOCTORS TALK BACK

Columbia General Hospital from 1914 to 1928, and I recall that we bought maggots to prepare leg ulcers for skin grafts. Six or eight maggots placed on the ulcer and confined by wire screening improved these cases immensely. Granted, this treatment is no longer common. But the doctor Mr. Belli holds up to scorn was medically correct."

They Complain Now

Says Washington State's Dr. Donald T. Hall: "Mr. Belli tells about one case in which a wart wasn't biopsied. Well, we doctors could biopsy every mole a patient shows us. Or order a chest X-ray for every patient with a cough. Or a gastrointestinal X-ray for every patient with a touch of dyspepsia. But patients already complain about the high cost of medical treatment. Imagine how they'd yell if these procedures were followed by every doctor for every small complaint!"

Difficult Diagnosis

Says New York's Dr. Herbert Berger: "Mr. Belli's account of his first malpractice case (the misdiagnosed appendicitis) shows how easy it is for the medically ignorant to jump at wrong conclusions. Diagnosis of appendicitis is one of the most difficult

from
pain
to
comfort
in
minutes
with



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Dose of three BIVAM tablets provides:

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Niacinamide	25 mg.
Ca, Calcium Pantothenate	5 mg.
Folic Acid	0.5 mg.
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Magnesium	3 mg.
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Iodine	0.1 mg.
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plus... multiple vitamins
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Clinical studies in thousands of gravid women show that optimal nutrition significantly reduces the incidence of abortions, premature births, stillbirths, toxemias and fatalities. Babies are healthier, less subject to illness.

BIVAM's phosphorus-free calcium minimizes leg cramps of pregnancy.

BIVAM is an excellent adjunct to C.V.P. in guarding against occurrence of capillary permeability and fragility which affect many pregnant women — to help reduce the risk of retroplacental bleeding, abortion, postpartum bleeding and erythroblastosis fetalis.

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DOCTORS TALK BACK

in all medicine. The incidence of error in identifying it varies from 20 to 50 per cent even in our finest medical centers."

The Brighter Side

It's apparent from the above excerpts—and from similar remarks in other letters—that most readers profoundly disagreed with Mr. Belli's article. A few correspondents point out, though, that the California lawyer did say much that needed saying.

To conclude, consider the following comment. It comes from

Dr. T. Stacy Lloyd of Fredericksburg, Va.:

"Mr. Belli is doubtless an outstanding attorney. Despite an apparently distorted outlook on the medical profession, he has a lot to say. It behooves us to listen. And I think we doctors have open enough minds to separate the chaff from the wheat. He says of his article: 'This should hold you for the time being.' Instead, I think it should serve as a jumping-off point for a thorough and impartial investigation of the malpractice problem by both medicine and law." END

when anxiety and tension "erupts" in the G. I. tract...

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Dosage: 1 tablet t.i.d. at mealtime. 2 tablets at bedtime.

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**a well tolerated, highly soluble
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For many urinary, respiratory and other bacterial infections...

... you'll find Terfonyl a drug of choice because of its high degree of efficacy, maximum safety and wide patient acceptability. To date, physicians have prescribed Terfonyl for millions of patients with excellent results.

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Tablets, 0.5 Gm., bottles of 100 and 1000.
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Benefits of Topical Salicylate in chronic rheumatic disease

Menthol-induced hyperemia plus high local concentration of salicylate has been recently rediscovered as one of the safest and most promptly effective remedies for rheumatoid discomfort due to exposure.



New, objective evidence:

A double-blind study¹ has reaffirmed the exceptional efficacy and safety of conservative, local treatment of chronic rheumatic disorders with BEN-GAY® (BAUME BENGUÉ), a high-concentration salicylate-menthol compound.

The local and systemic effects of BEN-GAY were evaluated by entirely objective methods in 211 subjects of both sexes suffering from various types of chronic arthritis, bursitis, neuralgia, myalgia and lumbago. Changes in range of joint motion were determined by goniometer and by flexion. Topical application of BEN-GAY measurably improved articular function in 94% when physical therapy was also used, and in 61% without adjunctive treatment. Efficient absorption of salicylate through the skin was indicated by an average urinary excretion of 15 mg. in 24 hours. No ill effects were reported or observed.

This controlled study offers new evidence of the efficacy and safety of local treatment of chronic rheumatic disease with BEN-GAY, one of the safest and most reliable formulae at the physician's disposal. BEN-GAY is available in two strengths, *Regular* and *Children's*. THOS. LEEMING & CO., INC., 155 East 44th St., New York 17, N.Y.

¹Brusch, C.A., et al.: Md. State Med. J.; 5:36, 1956.

More efficient salicylate penetration of treated area and quicker relief of pain is now made possible by water-washable, new GREASELESS-STAINLESS BEN-GAY.

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Index of Advertisers

Abbott Laboratories				Keystone Co. of Boston	
Placidyl	128,	176		Keystone Growth Fund Series K2	180
Optilets		181		Kinney & Company	
Selun and Iberol	Insert between 100,	101		Emetrol	43
Tropanthane		68		Lakeside Laboratories, Inc.	
American Cyanamid Company, Surgical Products Division				Neohydrin	63
Vim Needles and Syringes	10			Lederle Laboratories	
American Felsol Co.				Achromycin V	158, 159
Felsol Tablets	32			Falvin with Autrinic	182, 183
American Ferment Co., Inc.				Pathibamate	24, 40, 62, 102, 186, 202
Caroid and Bile Salts Tablets	26			Lloyd Brothers, Inc.	
American Sterilizer				Doxinate with Danthron	190, 191
Model 613-R Portable				Leeming & Co., Inc., Thos.	
High-Speed Autoclave	30			Baume Bengue	204
Ames Company, Inc.				Calmitol	146
Clinitext	98			Lilly & Company, Eli	
Ketostix	172			Amesec	143
Arnar-Stone Laboratories				Homicebrin	45
Americaine Topical Anesthetic				Ilotycin	135, 136, 137
Ointment	168			Mi-Cebrin	5
Aveno Corporation				Trinsicon	139
Aveno Oilated Colloidal Emollient				Tuinal	141
Baths	60			McNeil Laboratories, Inc.	
Ayerst Laboratories				Flexilon	129
Cothera Syrup	64, 65			Syndrox	165
Theruhiston	18, 19			Medical Economics, Inc.	
Babson's Reports, Inc.					32, 72
Stock Check	184			Medical Protective Company	
Bauer & Black—Div. of the Kendall Co.				Malpractice Insurance	184
Digest on the Therapy of Varicose Veins	65			Merck, Sharp & Dohme, Div. of Merck & Co., Inc.	
Belmont Laboratories				Cathozole	15
Mazon Dual Therapy	56			Diuril	IBC
Bircher Corporation, The				Merrell Company, The Wm. S.	
Spot-Quarts Ultraviolet Lamp	206			Bentyl	127
Borden Company				Nitranitol with Phenobarbitol	44
Bremil	150, 151			Quinctin	1FC, 166, 167
Burdick Corporation, The				Minnesota Mining & Mfg. Co.	
Burdick MW-1 Microwave Unit	12			Thermo-Fax Copying Products	157
Barroughs Wellcome & Co.				Mulford Colloid Laboratories	
Mareazine	28			Anergex	175
Carnation Company				National Drug Company, The	
Evaporated Milk	14			AVC	48
Central Pharmacal Company, The				Nepera Laboratories	
Neocyten	42			Biomydrin Nasal Spray	124
Synophylate	194			Parke, Davis & Company	
Cereal Institute, Inc.				Myadec	22
Basic Cereal Breakfast	195			Pfizer Laboratories, Div. of Chas. Pfizer & Co.	
Ciba Pharmaceuticals, Inc.				Ataraxoid	109
Pyribenzamine Expectorant with Codeine and Ephedrine	61			Cosa-Tetracycl	21, 23, 25, 27
Serpassil	123			Moderil	198
Vioform-Hydrocortisone Cream	133			Tyzine	57
Colewell Publishing Co.				Phillips Co., The Chas. H., Div. of Sterling Drug Inc.	
Professional Stationery	206			Haley's M-O	103
Crookes-Barnes Labs.				Picker X-Ray Corporation	
Lenic Complex	54, 114, 164			Century Diagnostic X-Ray Unit	41
Desitin Chemical Company				Pitman-Moore Company	
Desitin Ointment	112			Novahistine DH	52
Diene Company, The				Novahistine LP	50, 51
Meritene	187			Novahistine with Penicillin	49
Dame Chemicals				Professional Printing Company, Inc.	
Hist-A-Cort-E Creme	174			Histacount Bookkeeping System	115
Eaton Laboratories				Riker Laboratories, Inc.	
Furadantin	152, 153			Pentoxylon	37
Endo Laboratories, Inc.				Rauwiloid	117
Percodan	131			Robins Company, Inc., A. H.	
Florida Citrus Commission				Entozyme	16
Orange Juice	185			Pabalate/Pabalate-HC	162, 163
General Electric Company, X-Ray Dept.				Phenaphen Plus	66
Patrician	147			Roche Laboratories, Div. of Hoffmann-LaRoche, Inc.	
Holland-Rantos Company, Inc.				Marsilid	196, 197
Koromex Vaginal Jelly	170			Romilar CF	8
Hyland Laboratories					
Mumps Immune Globulin	206				

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INDEX OF ADVERTISERS

Roeig & Co., Inc., J. B.	
Antivert	160
Rorer, Inc., Wm. H.	
Manlox	177
Sandoz Pharmaceuticals	
Cafegot	107
Schering Corporation	
Metiderm	35, 36
Shield Laboratories	
Riasol	145
Smith, Kline & French Laboratories	
Compazine	38, 39
Daprisal	166
PSS	33
Sul-Spantab Tablets	46
Sul-Spansion Liquid	46
Thorazine Spansule	BC
Troph-Iron Tablets	67
Smith Co., Martin H.	
Dropspr	180
Squibb & Sons, E. R., (Div. of Olin-Mathieson Chem. Corp.)	
Mystecin-V	119
Pentide	53
Sumycin	4
Terfonyl	283
Strassenburgh Co., R. J.	
Tussionex	47
U. S. Air Force	
	169
U. S. Vitamin Corporation	
Bivam Tablets	200, 201
Upjohn Company, The	
Orinase	106
Wallace Laboratories, Div. of Carter Prods., Inc.	
Deprol	165
Mepro tabs	99
Milpath	53, 60
Miltown/Milprem	Insert between 68, 69
Warner-Chilcott Laboratories	
Agoral	20
Anusol	159
Calcealin	207
Peritrate	190
Plestran	178
Pyridium	188, 189
Tedral	121
Wyeth Laboratories	
Aludrox	111
Equanil	193
Polymagma	173
Zactirin	161
Zenith Radio Corporation, Hearing Aid Div.	
Zenith's Hearing Aid	29

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Memo

FROM THE PUBLISHER

'Don't Publish That!'

Almost every issue of MEDICAL ECONOMICS contains at least one article that someone has asked us *not* to publish.

Two weeks ago it was "Free Choice Has Failed." In this issue it's "Too Many Cooks at A.M.A. Headquarters?" In our next issue it's an article tentatively titled "Trouble in the Hospital." Two articles still further in the future—"Union Boss Bows to Private Medicine" and "This M.D. Is the Veteran's Best Friend"—are drawing vigorous objections right now.

Where do such objections come from—and why? From the people principally concerned, as a rule. Often they're involved in newsworthy developments that they don't regard as "good publicity" for themselves or their institutions. Often they generate a lot of pressure behind their point of view.

Resisting such pressure is one of our hardest jobs. But resist we must. For our primary aim is to help and inform all 148,000 of our physician-readers. Sometimes this means putting their collective in-

terests above those of any individual.

We don't do this willfully or without notice. Advance typescripts go out to the interested parties. And whenever someone says "Don't publish that!" we take the objection seriously. We re-research the article if the facts are in dispute. We ask ourselves once more: "Will this article serve some constructive purpose for the profession at large?"

If it will, we proceed with publication. We don't enjoy embarrassing people occasionally—especially if they're good friends. But only if we print facts as we find them can we fulfill the true purpose of an independent professional magazine.

Such a magazine, we firmly believe, can stimulate a good deal more constructive action than either viewers-with-alarm outside the profession or viewers-with-equanimity inside the ranks.

But constructive action is possible only when the truth is not varnished, when words are not minced, and when every side is given its say. —LANSING CHAPMAN